

HIV Nursing matters

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NSP 2012 - 2016 launched
Prescribing by nurses
Treatment of displaced populations



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**HIV
Nursing**
focuses on
management of
HIV services

on cover

- NSP 2012 - 2016 launched**
- Prescribing by nurses**
- Treatment of displaced
populations**

ed's note



This month commemorates two important annual events relating to HIV / AIDS treatment and care, namely '16-days of activism against Gender Violence' and 'World AIDS Day'

The 16 days of activism makes people aware of the negative impact of violence on women and children which contributes to the transfer of HIV, and to act against abuse in general. It is difficult to obtain reliable statistics on violence against women and children in South Africa. Although the number of reported cases is very high, many cases go unreported. The incidence of battery or intimate partner violence is particularly difficult to measure because the police do not collect separate statistics pertaining to cases of intimate partner violence as opposed to other categories of assault. In 1997 the Department of Justice estimated that one out of every four South African women are survivors of domestic

violence.¹

The motto for World AIDS Day 2011 is "Getting to Zero": Zero New HIV Infections, Zero Discrimination and Zero AIDS Related Deaths. This theme supports the drive for greater access to treatment and care for all people. South Africa is part of this drive and the new strategic plan will be launched on World AIDS Day.²

As the end of 2011 rapidly approaches many of us slow down for a well-deserved break. We hope all our readers find the opportunity to rest and enjoy the festive season. To those of you who keep the health services going during this period, thank you! We send our wishes for a safe month of service delivery.

1. www.womeninaction.co.za
2. www.worlddaidscampaign.org

HIV Nursing matters

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Message from the president



Professor Francois Venter,
President of the Southern
African HIV Clinicians' Society

**National
Strategic
Plan**
is planned for
release on
1 December

These are exciting times for the SA HIV Clinicians Society. By the time you read this, we should have a new Board of Directors and a new constitution (called a Memorandum of Incorporation, in accordance with SA's New Companies Act), in place. We were very pleased to have such a diverse, talented group of candidates for the Board. I will be stepping down as President of the Board when the new Board takes over in mid-December. The Society deserves new blood, and by the time you read this you should have it!

The last two years have been a period of consolidation and new opportuni-

ties, especially in the nursing arena. In addition, the new National Strategic Plan (NSP) should now be in your hands - it is planned for release on December 1st. The NSP has far reaching implications, especially for nurses, as it references the new Primary Care Revitalisation programme which places management responsibility for almost all primary care firmly in the hands of nurses. See, "An Overview of the South African National Strategic Plan, 2012-2016" on page 6 for a brief summary of the NSP. I have no doubt HIV Nursing Matters will be talking about the plan, and its implementation, in the year to come.

NHI pilot project to be rolled out in April

The challenge and the intent of NHI are to draw on the strengths of both healthcare sectors (public and private) to better service the public.

The Health Minister says implementation of NHI will be a gradual process. The first five years will be "a process of building and preparation" and NHI is to be phased in over 14 years. National Health Insurance (NHI) is to be piloted in 10 health districts from April 2012.

Implementing NHI is among President Jacob Zuma's priorities, as it will pro-

vide evidence that the ruling party is serious about the promises it made at its last elective conference in Polokwane in 2007.

Quality needed to be improved in the public sector, and soaring prices in the private sector needed to be brought under control, the Minister of Health said.

NHI contributions will be mandatory for everyone earning above a certain threshold, and will provide a defined basket of care to all citizens and legal long term residents, he said. NHI

will not cover items such as aesthetic cosmetic surgery that is not medically necessary, and "trendy spectacle frames", he said.

People will be able to continue to purchase medical scheme cover, and private sector healthcare providers will be free to choose whether or not to contract with the state.

By *Tamar Kahn*

Business Day, 11 August 2011

<http://www.businessday.co.za/Articles/Content.aspx?id=150495>



Confirmed: Medical Male Circumcision reduces risk of HIV transmission

CAPE TOWN – Three years after the start of a mass male circumcision programme in Orange Farm, Gauteng, there has been a marked decline in HIV transmission, researchers announced. The Orange Farm study provides the first "real world" evidence that medical male circumcision reduces the risk of men contracting HIV from female partners. This study bears out previous clinical trials in South Africa, Uganda and Kenya which demonstrated up to a 60% reduction in HIV transmission risk amongst circumcised men.

It provides important support for the recommendation by the World Health Organisation in 2007 that countries hard hit by HIV/AIDS introduce male circumcision programmes to help prevent the spread of the disease. The research lends fresh weight to Health Minister Aaron Motsoaledi's promotion of the procedure.

The president of the Southern African

HIV/AIDS Clinicians Society, Francois Venter, said the research was "very exciting".

The study was conducted by the nonprofit organisation Progressus and the National Institute of Communicable Diseases of the National Health Laboratory Service. Funding was provided by the French National Agency for Research on AIDS and Viral Hepatitis. The study offered free circumcision to men over the age of 15 who lived in Orange Farm. Over the three years, more than 20000 circumcisions were done. HIV incidence (a measure of the rate of infection) was 76% lower in circumcised men than in those who had not had the cut, while HIV prevalence (a snapshot of infections at a point in time) was 55% lower among those who had undergone the procedure. "This study is a fantastic result for a simple intervention which costs £40, takes 20 minutes and has to be done only once in a lifetime," said second researcher Prof David Lewis, from the

communicable diseases institute.

Dr Dirk Taljaard, from Progressus and one of the two South African investigators, said the study was also significant because it had found no evidence that men who had been circumcised adopted more risky sexual behaviour, a potential snag that had worried many experts in the field.

"There was absolutely no risk compensation," he said in a telephone interview from Rome. "But the sad part is that we do a lot of counselling, and that did not seem to have an effect," he said. Whether men had been circumcised or not, seemed to have no effect on the likelihood that they would use condoms or limit the number of sexual partners.

Tamar Kahn

Business Day, 21 July 2011

Full article available at <http://www.businessday.co.za/Articles/Content.aspx?id=148808>



HIV spread driven by number of partners, rather than concurrency

The spread of HIV is driven more by how many sexual partners a person has in their lifetime rather than having more than one lover at a time. This is according to extensive research conducted over five years by scientists from the Africa Centre in Umkhan-yakude district in rural KwaZulu-Natal. The results were published today (Friday 15 July) in the prestigious Lancet journal.

Debate has raged for years about the role that concurrent sexual partnerships (ie sexual partnerships that overlap in time) play in HIV transmission, with a number of experts arguing that concurrent partnerships are a key driver of the epidemic in Africa.

But according to Dr Frank Tanser, the study's principal investigator: "Our results clearly demonstrate the impact of multiple partnering on the transmission of HIV but we find no evidence to suggest that sexual partnerships that overlap (concurrent) are playing a disproportionately large role in driving the high rate of new infections."

Tanser and his team followed more than 7000 women who were all HIV negative to begin with. Almost 10 percent (693 women) became infected with HIV during the study. The researchers used questionnaires on sexual behaviour from almost 3000 men to inform their study. Using innovative geographical mapping,

the researchers plotted communities where men reported a high level of concurrent partners as well as these where men reported higher numbers of lifetime sexual partners.

"According to the Africa Centre, which is part of the University of KwaZulu-Natal, the results show that HIV prevention messages need to be clear and directed at reducing the number of sexual partners "irrespective of whether these partnerships overlap".

Kerry Cullinan
Health-e News Service, 15 July 2011
Full article available at <http://www.health-e.org.za/news/article.php?uid=20033210>



An Overview of the South African National Strategic Plan, 2012-2016

The National Strategic Plan (NSP) outlines the strategy and goals for South Africa to respond effectively to HIV, TB, and sexually transmitted infections (STIs). It serves to guide the development of provincial and sector implementation plans. Stacie Stender provides an overview of the NSP.



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**ZERO NEW HIV AND TB INFECTIONS
ZERO DEATHS FROM HIV AND TB
ZERO DISCRIMINATION**

The National Strategic Plan (NSP), 2012 - 2016, the third 5-year national strategy to focus on the leading causes of death and disability in South Africa, was launched on World AIDS Day, 1 December 2011.

The South African National AIDS Council (SANAC), composed of both government representatives and civil society organisations, was formed to ensure inclusion of civil society in the overall response to HIV and AIDS, as

well as to strengthen political leadership in addressing the disease. SANAC guided the development of the NSP through broad consultation over the course of several months.

The goals:

- ↑ **access and protection of rights**
- ↓ **burden of infection & disease**

Halve the number of new HIV infections
Ensure that at least 80% of people who are eligible for treatment for HIV are receiving it. At least 70% should be alive and still on treatment after 5 years
Halve the number of new TB infections and deaths from TB
Ensure the rights of people living with HIV are protected
Halve stigma related to HIV and TB

These goals will be reached through ensuring four things:

1. Addressing social and structural factors that drive these epidemics, that influence their impact, and that affect the way we care for affected people;
2. Preventing new HIV, STIs and TB infections through a combination of interventions;
3. Sustaining health and wellness, primarily by reducing deaths and disability from HIV and TB; and
4. Protecting the human rights of people living with HIV and improve their access to justice.

The primary objective of addressing social and structural factors is to address societal norms and behaviours that fuel the twin epidemics of HIV and TB. Structural interventions across all sectors, not only health, are essential to reduce vulnerability to, and mitigate the impacts of HIV and TB. Combination prevention is the foundation of preventing new HIV, TB and STI infections in South Africa, whereby biomedical, behavioural, social and structural interventions are addressed in concert. The third goal of sustained

health and wellness will focus on ensuring client access to quality treatment, care and support services – the focus of programmes to centre on wellness rather than disease. Finally, human rights of people living with HIV will be protected by putting an end to stigma, discrimination, human rights violations, and gender inequality.

How will the objectives be met?

The NSP will serve as a framework for the 9 provinces to draft their implementation plans. Provincial AIDS Councils will coordinate the planning – seize this opportunity to contribute to the strategy!

The provincial and sectoral level implementation plans will be launched on 24 March 2012 – World TB Day – for a start date for implementation of 1 April 2012. The action implementation of the NSP will depend on functioning systems and structures. SANAC has termed these essential elements ‘strategic enablers’ and have identified four core enablers:

- Effective and transparent governance and institutional arrangements ensuring that SANAC structures function

- effectively and efficiently
- Effective communication ensuring that information about the NSP and about the three diseases is shared as widely as possible
- Monitoring and evaluation ensuring that the progress of the plan is tracked and measured
- Research ensuring that SANAC shapes the national research agenda, has access to and shares information about the diseases and the response

As an HIV clinician, carer, concerned individual or advocate, you are a member of civil society who has important contributions to make regarding ensuring equitable access to quality HIV and TB prevention, care, and treatment services to all people of South Africa. Contact your Provincial AIDS Councils today to provide invaluable experience and ideas to this process that is founded upon transparency.



Tips on establishing a New HIV/AIDS Clinic

By: Limakatso Lebina, Mmatsie Manentsa
ZuziMpilo Clinic, Perinatal HIV Research Unit



NGOs are involved in service delivery and roll out of ARV treatment in the country. Establishing a dedicated ART clinic that meets the population needs requires extensive and detailed planning to ensure success as highlighted by this case study. Keeping sustainability in mind, readers are cautioned to consider the challenges of setting up ART clinics outside the planned DoH structure. It could be more prudent to seek added funding to be used on existing public platforms.

South Africa has an estimated HIV prevalence of 17,8% amongst 15-49yr.¹ Despite about 900 000 people currently receiving antiretrovirals, the Department of Health estimated there would be 2,75 million people requiring ARV's by 2012, a 1,85 million treatment gap.^{2,3} With the latest announcement from the Deputy President Kgalema Motlanthe that all people with a CD4 count below 350 will be given ART, the number of people needing ART will increase even more. To address this gap there will have to be an increase in the output of existing ART sites as well as the establishment of new ART sites will be required by maximizing existing resources through, for example, nurse initiated management of ART.

Groundwork

Community assessment

The first step in setting up an ART clinic in a specific community would be to assess the need and to know the target population. Understanding the key demographics such as the population size of the community and antenatal reports on HIV prevalence. Antenatal reports on HIV prevalence would also be useful. It is important to know what resources are currently available in that community and how the proposed ARV clinic would fit in with the health services that already exist. There are members of the community who are at high risk of acquiring HIV (Most-at-risk Population), this includes among others, sex workers, truck drivers and intravenous drug users. A comprehensive HIV Clinic should be accessible to these community members.

Community mobilisation

Community buy-in through involvement of its leaders and other advisory groups such as People Living With HIV/AIDs (PLWHA's) are important. Communication and extensive interaction with the key stakeholders about the plans to establish a clinic are critical. If the clinic will be established

in an existing Primary Health care centre it is advisable to conduct a small survey to assess the needs of the current facility users, and their thoughts on having an HIV clinic.

Resources and Logistics

1. Physical infrastructure

Adequate space is needed in order for all the functions of an ART clinic to run smoothly. Space requirements should include:⁵

- Comfortable and non-threatening waiting room
- Private space for counselling
- Secure pharmacy
- Space for support groups
- Staff room

2. Health care professionals

The staff requirements of an ART clinic can vary depending on specific task assignments.⁶ These need to be flexible in order to minimise the effect of healthcare worker shortages. Certain tasks, such as, counselling, minor administration or screening can be taken on by non-clinical staff to free up the workload of clinical staff in order to increase the number of patients seen and treated.

3. Laboratory services

Laboratory tests form an integral part of ART management and it's essential that a system is in place to ensure safe and reliable collection of specimens including fast turnaround time for results

4. Drug supply

The provision of a constant supply of ARV's is crucial. An effective system to manage the ordering, storage and dispensing of ARV's has to be in place.

5. Record System

Accurate data and record keeping is essential to ensure continuity of patient care, monitor drug supply and to ensure effective monitoring and evaluation. Electronic medical recording can be an effective tool to manage data efficiently although adequate training and IT support is needed.[f][g]

Services to offer

The function of an ART clinic goes beyond just providing ARV's to clients. There are many services that can be integrated into the clinic:

1. Education

Patient education is probably the most crucial step to ensure patient adherence to treatment, whether it's done through one-on-one sessions, group sessions or through educational tools and materials. It should be an ongoing process that is undertaken by every staff member. There should also be a dedicated education officer/counsellor on site.

2. Prevention

ART clinics are pivotal in the implementation of prevention strategies which include:

- Post exposure prophylaxis
- Male Medical Circumcision
- PMTCT

3. Support groups

Support groups in an ART clinic are an excellent way to engage with the psycho-social aspects of patients' lives which are sometimes neglected in clinical encounters. A support group is also a great tool to further educate patients by sharing the experiences of people living with HIV/AIDS

Types of Clinics or Funding Models

There are various funding options that could be sought to start an HIV Clinic- each has its own advantages and disadvantages. Most clinics are established and funded in partnerships. The Provincial and National Government of South Africa has committed to increasing the number of people accessing antiretroviral medication and would consider a proposal to set up a new ARV Clinic site. There are other international and national organisations that provide funding for HIV Clinics. Information on application and project proposal or areas of interest

can be found on their websites. Some of these organisations do not accept applications but select projects they would specifically like to fund. Major donor organisations such as USAID and Global fund often donate to one organisation (Primary Recipient) who will then seek partnership (Secondary Recipients) to accomplish the objectives as set out in the funding proposal.

Public Private Partnerships are an alternative funding source that can be established through community mobilisation and communication. A religious organisation (e.g. a church) or a company could fund some of the costs of running an HIV clinic, e.g. provide meals to PLWH Budgets

When a proposal is submitted to government or a funding organisation, a comprehensive budget is required. The highest figures are usually linked to personnel, medication and laboratory costs. Minor expenses could include rent, waste management, telecommunications and general office expenses. Resource sharing within an established health care facility could reduce some of the costs.

Reporting

HIV is a relatively new illness - continuous review and research is needed, therefore all stakeholders involved in the establishment of the clinic would like to receive regular reports on its performance. The reporting templates and requirements should be sought early on so that accurate data can be collected. It is advisable to strengthen existing structures such as the DHIS as developing parallel structures may not be sustainable.

Social Marketing

When the new ART clinic is close to being established, the targeted population needs to be informed of its services including operating hours, how to access the clinic and costs, if any. Word of mouth, flyers, posters, local radio stations and newspapers are

some of the less costly communication tools that could be used to spread the message.

Referral Partnerships

PLWHA often have complex medical and social needs. A referral system to access other services such as mental health support, legal advice, social services and specialist care is crucial in the holistic management of HIV. Partnerships could also be sought from other clinics in the area who conduct HCT services, and down-referrals from specialist facilities for stable patients.

Conclusion

The need to increase the number of facilities providing nurse-managed HIV/AIDS care in Southern Africa that is necessary in order to increase the number of people accessing antiretroviral care. This is by no means a comprehensive guide on starting an HIV clinic. It provides basic information that will need further research that will be guided by the situation and challenges for that particular facility. The establishment of a successful ART clinic will require determination, research, communication, relationships and funding.



HIV & AIDS Clinics

require research, communication, relationships and funding before it can be established

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Strengthening resilience and caring for the spirit of nurses in South Africa: A programme of research

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Staff support and motivation are some of the biggest challenges that a nursing service manager may encounter. This article reflects on strengthening the resilience of nurses and other health workers involved in the care of people living with HIV.

Nursing claims that 'caring' is the hallmark of the nursing profession. As such, all issues relating to caring are important to maintain the quality of care in the nursing profession. The ethical foundation of nursing is vested in the Nurses' Pledge and has been in use since the onset of nurses' training in South Africa. When taking the Pledge, the nurse enters into a verbal agreement with the community to always put the patient's needs first. This is a considerable promise to make and one that cannot be taken lightly, and it is therefore important for nurses to stay optimistic and keep the passion or the caring concern for patients to ensure high quality nursing care. This shows the importance of taking care of nurses.

The world of nursing is widely known for its high rates of staff turnover, absenteeism and burnout. Factors contributing to these issues include a high work load, poor collegial support, role conflict and role ambiguity. The perception of stress occurs when environmental demands exceed the individual's resources, leaving the nurse feeling hopeless and experiencing job dissatisfaction. South African nurses find themselves in this high risk, stressful work environment on a daily basis; this has an adverse effect on their physical health and emotional well-being. The literature indicates that professional nurses feel emotionally overloaded, stressed, fatigued, helpless, hopeless, angry, shocked, grieved, irritated, fearful, unsettled, frustrated, dissatisfied with their jobs, morally distressed and lacking in personal accomplishment; and for these reasons nurses often leave the profession. Recently the positive psychology movement has started building a science that aims at accumulating knowledge that will help individuals and organisations to promote personal satisfaction and resilience.

The nurse as an individual is a multi-dimensional being consisting of physical, emotional, intellectual and spiritual

dimensions which are integrated and dependent on one another. If not equipped to cope with all the stressors, the nurse will suffer as a whole; affecting every area of his/her life on a professional and personal level. This may also impact negatively on his/her resilience - the capacity to recover and maintain adaptive behaviour that follows initial retreat or incapacity after a stressful event or the ability to bounce back. In the most basic sense one can say resilience is a good outcome regardless of high demands, stress or risk. Resilience refers to healthy recovery and the capacity to mobilise resources and is described as a multi-dimensional construct. The question is: What is the prevalence of resilience in nurses, and how do they as individuals experience it?

The RISE programme of research

Against this background it became clear that further research on the resilience of nurses is needed in order to develop a comprehensive, multi-faceted approach to strengthen their resilience. This gave birth to the RISE programme of research. RISE stands for interventions to enhance resilience and spirituality and strives to strengthen the resilience of nurses, health caregivers as well as risk groups. In order to ensure a comprehensive perspective, we decided to broaden our focus and include other health caregivers as well as risk groups, such as HIV/ AIDS patients in our programme of research. In addition, authors found that spirituality plays a key role in unlocking resilience, and we realised that we should consider this in our programme of research. The following objectives further guide the programme, namely:

- To explore and describe the resilience of nurses, health caregivers and risk groups
- To implement and validate strategies developed by Koen, Van Eeden and Wissing (2010) to strengthen resilience of nurses

and other health care givers and risk groups

- To explore and describe caring for the spirit as an intervention to achieve the objectives of the programme.

RISE is still a work in progress striving to make a difference. The programme is positioned within Kumpfer's model of resilience and supports the Boyer model of scholarship, with the intention to integrate teaching, research, service and implementation of expertise. We are currently busy with the following projects:

Research

Research conducted by the authors and Masters degree students, independently as well as part of national and international research teams, explores and describes resilience and spirituality as the foundation of interventions to strengthen resilience of nurses, health caregivers as well as at-risk groups, such as HIV / AIDS patients.

Resilience workshops

Workshops are presented to nurses as well as other health caregivers to strengthen resilience, with a Strategies for Resilience booklet as tool. These strategies were developed based on findings from previous quantitative and qualitative research amongst nurses in the public and private sector in South Africa against the backdrop of Kumpfer's theoretical model of resilience on the building of strengths and protective factors as well as dealing with risk or hindering factors identified in the nursing profession.

During the workshops we share this scientific grounding of the development of strategies found in the booklet:

1. We Commit to Care
2. Care for the Caregivers
3. Work Well-Being
4. Environmental Mastery
5. A Personal Ethos

6. I Know Therefore I Can
7. Emotional Wellness
8. Build Well-Being Strengths
9. Restorative Self-Care
10. I Bounce Back

For example, the strategy “We Commit to Care” aims to use the uniqueness of the nursing profession to create a sense of pride and professional integrity in nursing. One action in this strategy is to reaffirm the Florence Nightingale ethos and strengthen the traditional values of respect, service, care and compassion.

We facilitate a group discussion on how the group can apply these strategies in their workplace. We use a “World Café” approach in these group discussions. This approach entails drawing on seven integrated design principles the methodology of which is a simple, effective and flexible format for hosting large group dialogue. World Café can be modified to meet a wide variety of needs. Specifics of context, numbers, purpose, location, and other circumstances are factored into each event’s unique invitation, design and question choice .

We close the workshop with a Caring for the spirit activity, namely that the group share a sensory stimulation experience with the purpose of relaxation and fostering connectedness.

Implementation of expertise

We offer several counselling, faith community nursing and mental health education services in our community. We continually involve nursing students in these services as a learning experience and also as a way of strengthening their well-being.

To conclude

Bearing in mind the adverse working conditions of nurses, the importance of opportunities to openly share with management and identify obstacles in

the work place can make a difference and help to motivate staff. The organisational climate is important; if goals are clarified and nurses can share their feelings then the climate will improve. Being happy at work is considered a fundamental element of a person’s life satisfaction and management of health facilities should cultivate this by improving management style, communication methods and working conditions. The support of management in workshops is to facilitate the nurses in their own growth and to ensure a positive outcome is achieved..

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Nurse managers

must ensure support and motivation of nurses & midwives who work with people living with HIV



Competition

A Day in the Life of a Rural Nurse

Nurses country-wide are working under enormous strain; many of their challenges were well captured in the Nursing Compact of April 2011. The growing burden of disease, the need for task-shifting, staffing shortages, poorly maintained facilities and drug stock-outs are but some of the challenges nurses are faced with on a daily basis. These problems are often amplified in the rural areas where resources are less and poverty levels are higher. Where distances are large and infrastructure poor or absent altogether. With quality of care and nursing attitudes under attack, we call for rural nurses to share with us a day of their life "in rural practice". Tell us what you love about your work; and what are

your daily challenges in providing quality care? In doing so, let us know how you would strengthen the local health system and how do you see the support roles of other health care workers?

Submit your max 1000 word piece TYPED word document to Laurie Schowalter at laurie@sahivsoc.org by 15 January, 2012 and stand a chance of having your piece published in *HIV Nursing Matters* and winning a new cellphone.

This competition is offered by the SA HIV Clinicians Society and the Rural Health Advocacy Project.

The Rural Health Advocacy Project (RHAP) is an advocacy

organisation in the field of rural health care. RHAP's work revolves around the right of rural and remote communities to have equitable access to comprehensive, quality health care. The Rural Health Advocacy Project is a partnership initiative between the Rural Doctors Association of Southern Africa (RuDASA), the Wits Centre for Rural Health (WCRH) and Section27, incorporating the AIDS Law Project. www.rhap.org.za

By participating you agree to have your picture taken and story published. The judges' decision is final and no correspondence will be entered into. Please note that only typed stories will be considered.

Rural Health 
Advocacy Project

Contraception & HIV

Jo-Anna Gorton, RN, BSN, BA



Considering that HIV prevalence is highest in women under 34 years of age, this article reflects on the important topic of contraception choices for women living with HIV.

In South Africa, the highest prevalence rates of HIV is in women aged 15-34 years. Most of these women engage in sexual relations and many desire to have biological children. Despite this reality, many women living with HIV do not access family planning services. The consequences of this, which may include an unplanned pregnancy or the accidental transmission of HIV from mother to child, are significant - both on a public health level and for women themselves. Nurses must be prepared to provide family services to women living with HIV. This includes the provision of contraceptives and access to counselling which is the right of all women living with HIV. Receiving this care can support women in having safer sex as well as beginning a family when the time is right for them and the risk of HIV transmission to their children is minimised.

Contraception Basics and Safety

Contraception is a variety of technologies and methods that prevent the process of fertilisation. The definition of fertilisation is the fusion of sperm and a woman's ovum, usually following sexual intercourse and the ejaculation of sperm into a woman's vagina. This process takes place in a woman's uterus.

We know that the best choice of contraceptive for a woman is one that she has chosen herself and feels most comfortable using. From a medical standpoint, we need to ensure that the method chosen by our patients is safe and likely to be used correctly and consistently. When considering contraceptive safety, nurses can use the World Health Organization (WHO) guidelines. These guidelines are available online for free (see link at the end of this article) and large clinics should have hard copies available. These guidelines explore the safety of each type of contraceptive with major medical conditions

(including HIV). Using them can ensure that women with pre-existing medical conditions are not exposed to further risk; and also that women who do have pre-existing conditions are not denied access to contraceptives that are perfectly safe. Patients with complex medical histories and conditions might need to consult a physician and/or pharmacist if one is available.

Contraception and HIV

There are many safe and effective methods of contraception available for women with HIV. As discussed above, the need to provide comprehensive and evidence-based information and services around family planning to HIV-positive women is particularly important. Unplanned pregnancies can lead to the vertical transmission of HIV from a mother to a child if women do not seek antenatal care in time. In addition, some antiretrovirals (ARVs) have teratogenic effects on a growing fetus meaning a change in ARV regimen might be required to keep the baby safe as it grows in the uterus. Good family planning can also ensure that women have children when they are ready, e.g. when they are finished schooling.

A conversation about contraceptives with any client will inevitably touch on the topic of sex. For women with HIV this can be a particularly difficult discussion; having HIV can change the way a woman feels about her sexuality and there are strong societal beliefs about what is "appropriate" behavior and what isn't. Nurses need to ensure they do have these conversations with their patients - in so doing patients can be assessed for their safety in a relationship and ensure they are aware of how the virus is transmitted. Most contraceptives do not provide any protection against HIV transmission, it is extremely important that nurses emphasise this in conversations with their clients. Recommending **dual-**

method contraception involving both condoms and a hormonal contraceptive provides the best protection against pregnancy, STIs and HIV transmission.

Providing Contraception Counselling and Services

Barrier Methods - Condoms

Male condoms act as a physical barrier to pregnancy by preventing ejaculate from entering the vagina. This barrier also protects against transmitting and receiving most sexually transmitted infections (STIs), including HIV. Condoms must be used correctly and every time a woman has sex in order to be effective. Unfortunately this is not always the case; male condoms have a relatively high failure rate (15% of couples using only condoms for pregnancy prevention still get pregnant in one year). Nurses can ensure that couples understand how to use and access condoms.

Female condoms are also available in South Africa. Like male condoms they work by blocking ejaculate from entering the vagina. The estimated failure rate for female condoms at preventing pregnancy is, like male condoms, quite high (26%). This is attributed to inconsistent and incorrect use. It is important to instruct clients on how to use female condoms properly in order to prevent HIV transmission and recommend dual method contraceptives to provide maximum protection against unwanted pregnancies.

Short and Long-Acting Contraceptives

Besides condoms, women in South Africa mainly use injectables, sterilisation and the birth control pill to prevent pregnancy. Most contraceptives are safe for HIV positive women to use; yet extra consideration is required before initiating contraceptives in a woman with HIV or continuing them after an

HIV diagnosis. When doing an assessment for contraceptives, a nurse needs to know if a woman has advanced HIV disease or if she is on ARVs or treatment for Tuberculosis (TB). Below is an introduction to the major types of birth control and their safety in women with HIV. None of these methods provide protection against STIs or HIV transmission.

Short-Acting Contraceptives

Oral Contraceptives (The Pill)

The birth control pill is enjoyed by many women and highly effective if used correctly. Generally the birth control pill contains estrogen and progesterone and is taken daily. For women with HIV, caution must be exercised when recommending the pill if a woman is taking ARVs. Some ARVs can reduce the efficacy of the birth control pill, particularly Ritonavir and some ARVs from the NNRTI class. Rifampicin, a medicine used to treat TB, can also reduce the efficacy of birth control. Before initiating birth control, a nurse can consult the WHO safety document for contraceptives mentioned above, or consider another form of contraceptive. If a woman has a strong desire to take or continue with the pill, a type with an estrogen profile of at least 30mcg to as high as 50mcg can be considered in addition to consulting a pharmacist or physician. For HIV positive women not on ARVs there is no contraindication to taking the birth control pill. More research on other short-acting hormonal contraceptives such as the patch, sponge and ring is needed before their safety and efficacy with ARVs is known.

Injectables

Depot Medroxyprogesterone Acetate (known as the Depo Shot or the Injectable) is a highly effective hormonal contraceptive that is injected into a woman every three months. Injectables are a good choice for women on ARVs (including NNRTI & PIs) or

Rifampicin as there are no known interactions between these medications and the injectable. Importantly, prolonged use of injectables can put women at risk for low bone density. Nurses must consider if women have pre-existing issues with bone mineral density before recommending injectables; and for women using this contraceptive method nurses must promote the intake of calcium, regular weight bearing exercise and a reduction in smoking & alcohol consumption. Nurses must also take caution using the injectable in women wanting to have children in a hurry as it can take 10-18 months for menstruation to return after prolonged depot use. Because women must return to the clinic every three months for injectables, nurses must also ensure that the clinic has capacity to meet this need. Recently published evidence, some of it from South Africa, has linked injectables with an increased risk of HIV transmission. As stated above, using condoms alongside hormonal contraceptives is the most effective way to protect against both pregnancy and HIV transmission, and should be emphasized with clients during every clinic visit.

Long-acting Contraceptives

Intrauterine Devices

Intrauterine devices (IUDs) are small copper or hormonal devices that are inserted into a woman's uterus using safe and sterile technique. IUDs are highly effective (only a 0.1% failure rate), well liked, safe and cost-effective. They are particularly appropriate for women wanting kids in three years or more; or for women considering sterilisation but who are not completely sure. Generally IUDs are safe for women with HIV (treatment or not) but caution does need to be taken as women are at a slightly increased risk of developing pelvic infections after an IUD is inserted. Close monitoring for signs and symptoms of an infection is required in the first few days after an



IUD is inserted.

Recent surveys show that many nurses in South Africa would like to learn how to insert and remove IUDs and there is a growing interest among clients about this form of contraception. As professionals, nurses must demand and create training opportunities to increase the availability of this service and ensure that they provide accurate information to their clients about IUDs.

Sterilisation

Most women know about sterilisation in South Africa and believe it is the best long-term protection against pregnancy. Sterilisation can be a good choice for women as it is life long, effective, safe and simple. However, it is not a good choice for women who are undecided about pregnancy or victims of misinformation; especially when it comes to discussions about HIV transmission and pregnancy. Accurate information must be provided to a woman considering sterilisation and the procedure performed by a trained physician. Sterilisation does not provide protection against STIs or HIV transmission.

Conclusion

This article provides an introduction to the basics of contraception for our HIV positive clients. Although this is not an area of health services that is commonly discussed, it is imperative that we ensure all our clients have access to comprehensive and relevant family planning services. For HIV positive women this can help ensure that they have children when they choose to and with little risk of HIV transmission to their children. HIV positive women have many choices when it comes to contraceptives; the nurses role is to facilitate this choice by offering accurate information and services.

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Nurses must
facilitate women's
contraceptive
choices by offering
accurate information
and services

®

clinical tips

Splenomegaly



The spleen is part of the lymphatic system with the following important functions:

- It filters blood and removes old and damaged red blood cells, bacteria, and other particles as they pass through the blood vessels within the spleen.
- It produces lymphocytes and monocytes which assists the immune system.

Enlargement of the spleen (splenomegaly)

Due to the involvement of the spleen in fighting infection, part of its response is to enlarge, as seen in bacterial and viral infections such as AIDS and viral hepatitis. The enlarged spleen tip can be felt in the left upper quadrant of the abdomen and as it continues to enlarge the tip moves towards the right lower quadrant.

An enlarged spleen itself usually does not cause any symptoms. More often the patient seeks healthcare services for symptoms of an underlying disease. Enlargement of the spleen can cause pressure against the diaphragm which in turn causes irritation and a referred pain to the shoulder. Pressure

against the stomach may cause loss of appetite, a feeling of early fullness when eating, or anorexia. An enlarged spleen protrudes from under the ribcage and may easily be injured.

Diagnosing an enlarged spleen

The spleen is normally not palpable. Enlargement of the spleen takes place anteriorly, down ward and medially with the result that the tympany of the stomach and colon are replaced with the dullness of a solid organ. Enlargement can be determined by the following techniques.

- Percussion of the spleen is done posterior to the midaxillary line on the left side. Normally a small area of splenic dullness may be heard between the sixth to the tenth rib. Percuss the lowest intercostal space in the left anterior line before and after the patient takes a deep breath. The area should remain tympanic. With splenic enlargement the tympanic sound changes to dullness as the spleen moves anteriorly and downward during inspiration.
- Palpation of the spleen is performed on the left side of the

patient, just left of the mid clavicular line at the end of the rib cage. Stand on the right side of the patient, reach over and place the left hand under the lower part of the rib cage to support and press forward the left rib cage and soft tissue. Place the palmar surface of the right hand with fingers extended on the patient's abdomen below the left costal margin. Use the findings from percussion as a guide. Palpate with the points of the fingers of the right hand along the rib cage for the spleen by pressing fingers inward towards the spleen when the patient takes a deep breath. If you cannot feel the spleen, ask the patient to turn on the right side pulling up his the knees to the chest and repeat palpation. Due to the direction of spleen enlargement, it may be easy to miss the spleen. If there is any indication of splenomegaly in the history of the patient, it may be necessary to palpate towards the fossa iliaca.

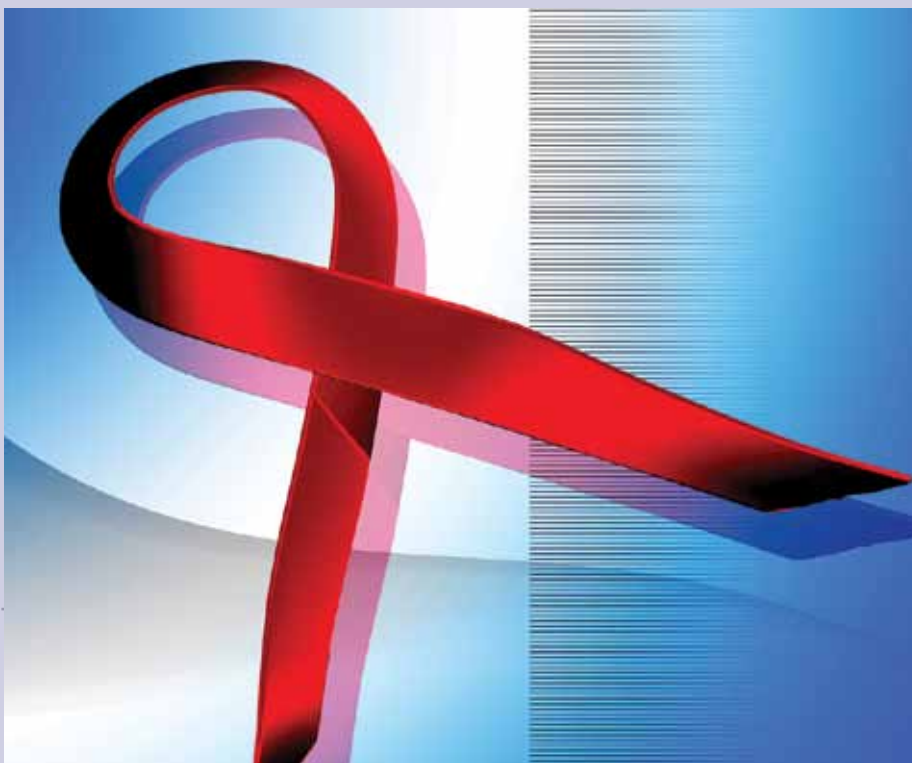
Gentle palpation, especially in children, is the best approach. Classify enlargement by numbering the cm of enlargement from under the rib cage in the midclavicular line.

Treatment

Treatment of an enlarged spleen is directed at the underlying disease causing the enlargement.

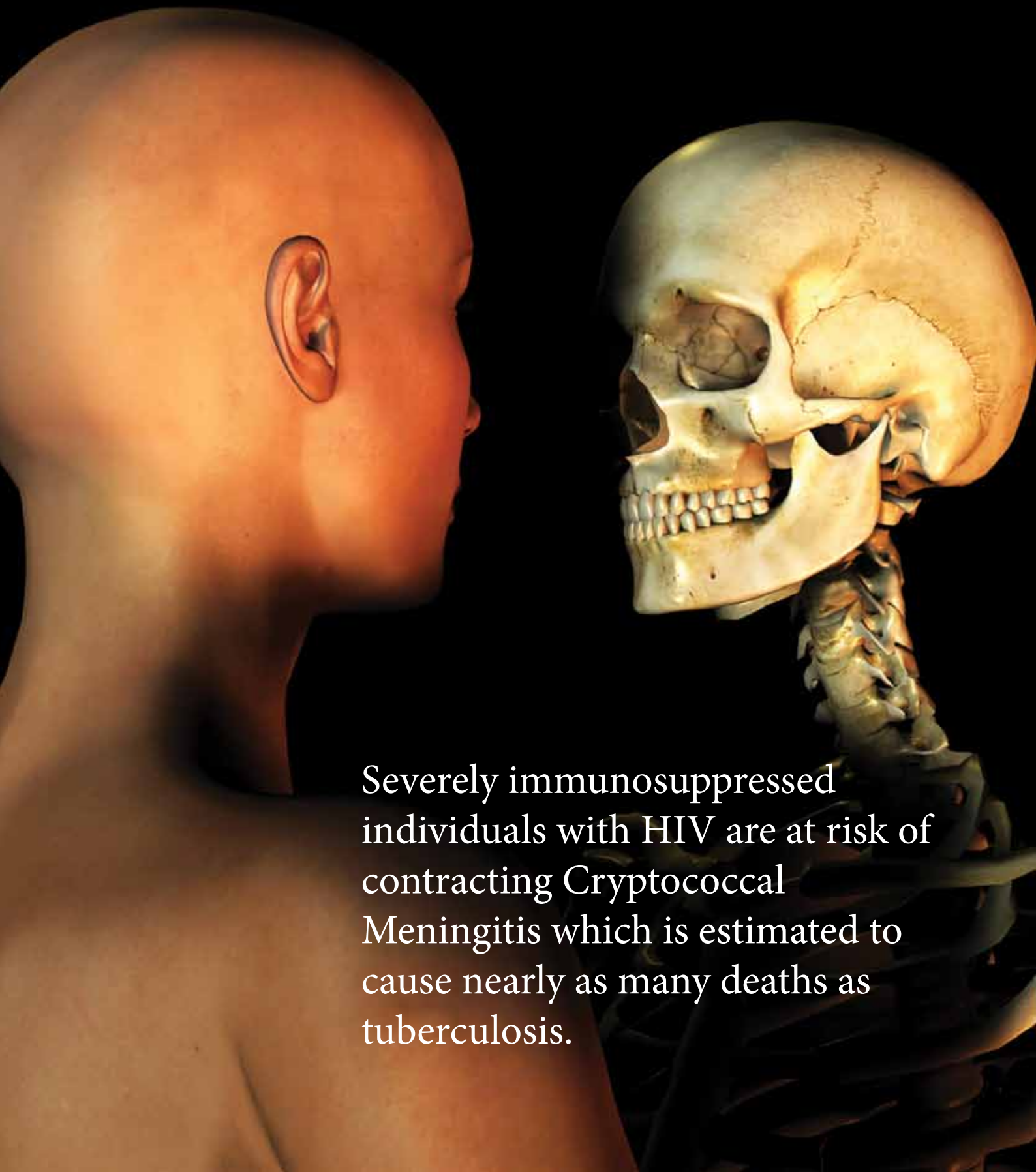
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HIV
Nursing
tips for
assessing an
enlarged spleen



Cryptococcal Death Prevention: A New Way Forward

Nelesh Govender, Mycology Reference Unit, National Institute of Communicable Diseases, a division of the National Health Laboratory Service;
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Severely immunosuppressed individuals with HIV are at risk of contracting Cryptococcal Meningitis which is estimated to cause nearly as many deaths as tuberculosis.

Cryptococcal meningitis, a fungal disease caused by *Cryptococcus* spp, is a leading cause of death among severely immunosuppressed individuals with HIV/AIDS and the most common cause of adult meningitis in most of sub-Saharan Africa. (1) Approximately 50% of patients with cryptococcal disease in this region will die. (2) In South Africa, it is estimated to cause nearly as many deaths as tuberculosis: between 2005 and 2010, there were over 25,000 cryptococcal-related deaths compared with 30,000 TB-related deaths in that same period (Govender N, unpublished data). Patients are at risk for dying from cryptococcal disease both prior to initiating anti-retroviral treatment (ART) and in the immediate post-ART initiation period due to IRIS (immune reconstitution inflammatory syndrome). (3-4) Issues with lumbar puncture and amphotericin B availability, compliance with fluconazole maintenance therapy, and delayed initiation of ART have all contributed to the high death rates. Yet despite the huge morbidity and mortality from this disease, little has been done to prevent cryptococcal meningitis or address this important public health issue.

Currently, there are no widespread programmes to prevent cryptococcal disease. One strategy is to detect early disease (by measuring cryptococcal antigen (CrAg)) prior to symptom development and to pre-emptively treat with a low-cost oral medication, fluconazole. Recently, a new test to detect cryptococcal antigen has been developed. (5-6) This new assay is a dipstick test that is inexpensive and accurate (>99% sensitivity and specificity) (Immuno Mycologics, Oklahoma, USA). (5-6) It is simple to use, stable at room temperature, and can be used on blood, urine, or cerebrospinal (CSF).

Cryptococcal antigen is detectable in the blood, days to months before patients develop overt symptoms of meningitis. Studies from Cape Town show that the CrAg test has a high negative predictive value: of patients entering an ART programme who were serum CrAg negative, none subsequently

developed cryptococcal meningitis at 1-year follow-up. (7) Conversely, of those who tested positive, approximately one-third developed meningitis. Another study in Uganda has demonstrated that treating patients who are CrAg positive with ART alone is not enough: there was an increased risk of death when CrAg-positive patients were not treated with fluconazole. This same study showed that screening patients for cryptococcal antigen and pre-emptively treating them with fluconazole was a cost-effective strategy in HIV/AIDS populations where CrAg positivity is greater than 3%. In South Africa, prevalence ranges from 3 to 13% depending on the population studied. (7, Govender, N, unpublished data) The highest prevalence is found in those patients with a CD4 count less than 100 (7) therefore targeted efforts to screen for CrAg would be most effective in this group.

In implementing a widespread cryptococcal screening program to prevent death, there are several important considerations. Screening can be done either as a point-of-care test or in the laboratory. The laboratory approach allows for immediate reflex testing: remnant blood from any CD4 count sample less than 100 can be used to test for cryptococcal antigen using the novel dipstick test. CrAg results are reported back to the physician with the CD4 count results.

Current research is underway to determine the necessity of lumbar puncture in establishing meningeal involvement of cryptococcal disease, the exact timing for ART initiation after initial treatment, and the most cost-effective dose and length of fluconazole therapy in asymptomatic patients. In the mean time, experts have recommended a management strategy balancing risks and benefits based on current data (8)

In 2012, South Africa will pilot a laboratory-based cryptococcal screening programme to prevent cryptococcal deaths. Like already established programmes such as cotrimoxazole prophylaxis, isoniazid preventive therapy (IPT), and cervical cancer

screening, cryptococcal screening is likely to become an integral part of adult HIV/AIDS care. This program can reduce hospital costs, improve the health and wellness of South Africans and increase life expectancy. Most importantly, it could potentially save thousands of lives a year in South Africa.



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WHAT IS THE CURRENT SITUATION FOR NURSES KEEPING, PRESCRIBING AND SUPPLYING MEDICINES?

Hasina Subedar, Consultant

Prescribing treatment remains a challenging management issue in service delivery. This article seeks to share the facts and provide clarity regarding the common misconceptions surrounding this issue.

In South Africa, registered nurses were authorised to assess, diagnose and prescribe treatment for certain conditions as far back as 1984. Since this provision was introduced nurses played a major role in improving access to primary health care services especially in rural and underserved areas. The restructured health services post 1994 had a greater emphasis on PHC services and relied on nurses heavily; especially those who obtained a qualification in Clinical Nursing Science, Health Assessment, Treatment and Care. These nurses have played a vital role in improving access to public health by providing PHC services across the country.

Despite the importance and prominence of this role being widely acclaimed, there appears to be widespread confusion and lack of clarity regarding the current situation under which nurses may assess, diagnose and prescribe treatment.

Historical Background

Section 38A of the Nursing Act of 1978 (Act No. 50 of 1978) which enabled nurses to assess, diagnose and prescribe treatment did not apply to all registered nurses. Only a registered nurse in the service of the Department of Health, a provincial administration, a local authority or an organisation performing any health service and designated by the Director-General of Health, where there is no medical practitioner or pharmacist may:

- conduct a physical examination of any person;
- diagnose any physical defect, illness or deficiency in any person;
- keep prescribed medicines and supply, administer or prescribe these according to prescribed conditions; or
- promote family planning.

An example of health services that have been designated by the Director-General of Health, would be, the occupational health services industry.

In 1984 the Minister of Health and Welfare made the "Regulations Relating to the Keeping, Supply, Administering or Prescribing of Medicines by Registered Nurses" that prescribed what medicines a nurse is duly authorised to keep, prescribe and supply. According to these regulations a registered nurse authorised in terms of section 38A of Nursing Act of 1978 may, keep, supply, administer or prescribe for the use of a person an unscheduled medicine and any medicine or substance listed in Schedule 1, Schedule 2, Schedule 3 or Schedule 4 to the Medicines Control Act, 1965.

Current Situation

In 2007 a new Nursing Act (Act 33 of 2005) was promulgated and whilst section 56 of this Act makes exactly the same provisions for authorisation as section 38A of Act 50 of 1978 there are some fundamental differences. The key difference being that the South African Nursing Council is now required to register a professional nurse, a midwife or a staff nurse to assess, diagnose, prescribe treatment, keep and supply medication for prescribed illnesses and health related conditions. Proof of having completed a prescribed qualification and payment of a registration fee and proof of authorisation are pre requisites for registration by the SANC. The registration certificate is only valid for a period of three years which implies that this registration must be renewed and the SANC may impose conditions for renewal.

Whilst section 56 (1) of the Act provides for new regulations to be made, these are not finalised as yet. Section 61 makes provision for the existing regulations and authorisations made in terms of the repealed Act to remain in force. Therefore the authorisations granted in terms of section 38A are considered to be made in terms of section 56(6) which is the corresponding section to section 38A. The Regulations Relating to the Keeping, Supply,

Administering or Prescribing of Medicines by Registered Nurses published in government notice number R 2418 of 2 November 1984 remains in force until they are repealed.

Frequently Asked Questions

Are new Regulations required for registered nurses before they can continue to assess, diagnose and prescribe, keep and supply medicines?

Registered nurses that were authorised and carried out this function in terms of Section 38A of the nursing Act No 50 of 1978, may continue to render the function that they were authorised to do so. Both section 38A and the regulations made in terms of this section remain in force until they are repealed.

What are the education and training requirements for a nurse to assess, diagnose and prescribe treatment?

At present there are no standardised education and training requirements. There are various training programmes, however, the Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care is the qualification most frequently done by nurses in the primary health care settings. Section 56 (1)(a) stipulates that for a person to be registered, qualification and training requirements must be "prescribed" (means prescribed by regulation). At this stage there are no "prescribed" qualifications or training requirements. Until such time the Minister of Health makes regulations the status quo will remain to ensure that nurses who are authorised to assess, diagnose and prescribe, keep and supply medicines have required level of knowledge and competence to do so.

Can nurses working in the private sector or in private practice assess, diagnose and prescribe, keep and supply medicines

The Nursing Act 33 of 2005 does not make provision for either nurses in the

private sector or in private practice to assess, diagnose and prescribe, keep and supply medicines. However a midwife who is in private practice may in terms of the section 22A(15) Medicine Control Act apply for a permit to keep and use medicines required to practise his/her profession in terms of the scope of practice of a midwife. Midwives are permitted to use drugs such as Pethidine, Neonatal Narcan, Vitamin K and Oxytocin. Section 56(6) furthermore makes provision for the Director General to designate a service as a health service where nurses can be authorized to diagnose and prescribe treatment. The only private health service where this is currently found, is at occupational health services in industry where the employer provides a health service to its workers.

Can a nurse prescribe contraception (family planning)?

A nurse authorised in terms of section 56 (6) may, keep, supply, administer or prescribe for the use of a person an unscheduled medicine and any medicine or substance listed in Schedule 1, Schedule 2, Schedule 3 or Schedule 4 to the Medicines Control Act. In terms of this provision a nurse may, keep, supply, administer or prescribe for the use of a person all contraceptives including emergency contraception that are included in the aforementioned schedules.

Can a nurse who leaves a public health facility use the sections 38A or 56 (6) Authorisation

The sections 38A or 56(6) authorisations granted to a nurse is only applicable if the nurse is in the service of the Department of Health, a provincial administration, a local authority or an organisation performing any health service and designated by the Director-General: Health. The section 38A/56(6) authorisation issued to a nurse is not transferable to another nurse nor is it transferable to another service. A new section 56(6) authorisation is required for each context within which nurse is required to function in terms of this section by the designated medical practitioner.

Can a nurse authorised in terms of section 38A or 56 (6) offer services to the public and charge a fee for such services

No a nurse is only permitted to assess, diagnose and prescribe, keep and supply medicines whilst in the service of the Department of Health, a provincial administration, a local authority or

an organisation performing any health service and designated by the Director-General: Health. The services alluded to are all public health facilities and the nurse by implication is an employee of the public authority responsible

for providing service and therefore cannot bill a client in her individual capacity for these services.

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1. The nurse is in the service of the Department of Health, a provincial administration, a local authority or an organisation performing any health service and is designated by the Director-General: Health to do so.
2. **Section 61(1)** "Any proclamation, notice, regulation, authorisation or order issued, made or granted, any registration or enrolment, any removal from a register or roll or any appointment or any other thing done in terms of a provision of any law repealed by section 60(1) is, unless inconsistent with any provision of this Act, deemed to have been issued, made, granted or done under the corresponding provision of this Act." Nursing Act 33 of 2005
3. Government Gazette No.R.2418 of 2 November 1984 Regulations relating to the keeping, supply, administering or prescribing of medicines by Registered Nurses
4. **Section 61.**"(1)Any proclamation, notice, regulation, authorisation or order issued, made or granted, any registration or enrolment, any removal from a register or roll or any appointment or any other thing done in terms of a provision of any law repealed by section 60(1) is, unless inconsistent with any provision of this Act, deemed to have been issued, made, granted or done under the corresponding provision of this Act." Nursing Act 33 of 2005





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CONFERENCE PROGRAMME

TUESDAY, 12 JUNE 2012

16h00 - 17h30 Conference Opening

WEDNESDAY, 13 JUNE 2012

09h00 - 10h30 Plenary
10h30 - 11h00 Morning Refreshments
11h00 - 12h30 Parallel Sessions
12h30 - 14h00 Lunch
14h00 - 15h30 Parallel Sessions
15h30 - 16h00 Afternoon Refreshments
16h00 - 17h30 Parallel Sessions

THURSDAY, 14 JUNE 2012

09h00 - 10h30 Plenary
10h30 - 11h00 Morning Refreshments
11h00 - 12h30 Parallel Sessions
12h30 - 14h00 Lunch
14h00 - 15h30 Parallel Sessions
15h30 - 16h00 Afternoon Refreshments
16h00 - 17h30 Parallel Sessions

FRIDAY, 15 JUNE 2012

09h00 - 10h30 Late Breaker Sessions
10h30 - 11h00 Morning Refreshments
11h00 - 12h30 Conference Close



Reaching the Target

IMPORTANT DATES

1 Sept 2011 - Early registration, scholarship application and abstract submission opens

14 Dec 2011 - Regular registration opens

20 Jan 2012 - Close of abstract submission and scholarship application

9 Mar 2012 - Notifications of abstracts

18 May 2012 - Regular registration closes

12 June 2012 - On-site registration opens

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Clinical Guidelines for antiretroviral therapy management for displaced populations in Southern Africa



All displaced populations have the right to access HIV-related services. The SA HIV Clinicians' Society developed clinical guidelines for antiretroviral therapy management for displaced populations in Southern Africa. These guidelines can be downloaded from the website (www.sahivsoc.org)

Providing HIV-related services to displaced populations is a difficult yet critical undertaking, which is firmly rooted in international human rights law. Protection offered under this law, particularly, Article 12 of the International Covenant on Economic, Social and Cultural Rights; confirms "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". This right requires health workers to take steps that are necessary for "the creation of conditions which would assure to all medical service and medical attention in the event of sickness".

In addition, health workers who treat displaced persons are guided by the same principles that govern the treatment of any patient before them, irrespective of nationality or ethnic origin, which include an intrinsic respect for human life and an oath to act in the patient's best interest when providing medical care. Nonetheless, displaced persons are a unique group with special needs. They are often stigmatised, marginalised and discriminated against, making them highly vulnerable and insecure in their host country. Those in need of treatment are often denied care. However, since the rollout of affordable antiretroviral therapy (ART) worldwide, there has been an international push to recognise every individual's right to treatment and to ensure universal access to ART. Displaced persons often come from communities that are least likely to have access to ART, and health workers will be following international law and practice by providing treatment to them.

For those who are already on treatment, health workers often need guidance regarding complications that may arise due to differences in regimens or, if initiated in the host country, due to different conditions the individual may face at their new treatment site. The management of ART in displaced populations requires health workers to

make strategic choices regarding the best care for the individual who may be further displaced. These guidelines outline key principles to guide the health worker in making these complex choices.

Scope of application

This policy is intended to offer guidance to clinicians, non-governmental organisations (NGOs) and governments on the provision of ART among displaced populations, including Prevention of Mother-to-Child Transmission (PMTCT), Post-Exposure Prophylaxis (PEP) and long term ART. These guidelines are not meant to replace national guidelines but to provide additional guidance to health workers to deal with the specific needs of these populations. As with all HIV / AIDS policies and programmes, ART must be linked to prevention, care and support programmes. ART should not be implemented as a parallel intervention but as part of an integrated programme that is linked to other existing services (e.g. reproductive health, nutrition, education and social services).

The guidance set forth in this document applies to all displaced populations, including refugees, asylum seekers, internally displaced persons and migrants. Specific guidance is necessary not only due to the unique characteristics of these populations, but also their vulnerabilities and frequent exclusion from HIV and AIDS related services. It is widely recognised that the failure to provide HIV prevention and care to displaced persons not only undermines effective HIV prevention and care efforts, it also undermines effective HIV prevention and care for host country populations.

Background

Southern Africa is host to approximately 300,000 refugees and asylum seekers, the majority of whom are hosted in South Africa and Zambia. Most refugees and asylum seekers are currently coming from countries

with lower HIV prevalence, such as the Democratic Republic of the Congo (DRC) and moving to countries with higher HIV prevalence, such as South Africa. Their vulnerability to HIV infection, therefore, increases upon arrival. In general, they also come from areas where access to ART is limited.

The number of migrants in the region is difficult to estimate accurately, as there are no official mechanisms for recording these figures. However, every country in southern Africa is affected by migration, either as a source or destination country.

Definitions

Refugee: a person who flees his/her own country because of race, religion, nationality, membership of a particular social group, political opinion or civil unrest/war, and who cannot return home for fear of persecution

Asylum seeker: a person who has applied for asylum and is awaiting a decision on his/her case

Internally displaced person: person who has been forced to flee his/her home suddenly or unexpectedly due to armed conflict, internal strife, systematic violations of human rights or natural disasters, and who is still within the territory of his/her country

Economic migrant: person who moves to another country seeking economic opportunities

Undocumented migrant (often negatively referred to as 'illegal immigrant'): person who has entered another country and remains without the required legal documentation

"They see refugees as a threat, as competing for their jobs and women. Nobody sees them as a victim of circumstances." - Refugee in Johannesburg referring to local services.

Mythbusters*Conflict always increases HIV*

On the contrary, despite the sexual violence, trauma and breakdown of family & community structures, evidence suggests that there are 'protective' factors in a refugee setting that may offset these risks. Furthermore, displaced persons often come from countries of origin with lower HIV prevalence and move to countries of asylum with higher HIV prevalence. Thus, these populations often have lower HIV prevalence than their surrounding host communities, particularly in southern Africa.

Displaced persons engage in high risk behaviour

While displaced persons are vulnerable to exploitation and abuse, they have often benefitted from the assistance of international organisations. For example, dedicated HIV awareness programmes and training in many refugee camps has resulted in a high level of skills and knowledge with less risky behaviour. Displaced people can use this knowledge in their country of asylum as well as in their home country upon their return

High mobility among displaced persons prohibits good adherence

Displaced persons are often denied access to care for fear that they are too mobile. However, by the end of 2003, refugee populations remained on average in their host country for 17 years. Even within a country, they are far less mobile than many assume.

Providing access to HIV and AIDS-related care will result in increased activity across the border. The more people can access such services, the higher the tendency to remain. This is evident in countries that have provided free ART to refugees..

Displaced persons never have support structures

There are often tight and extensive

support networks of similarly affected people within the host community; these may, however, not involve family, friends or more traditional support networks. Often innovative ways of ensuring adherence to ART, such as using clinical staff, counsellors and support groups, have proven effective.

Conflict is limited to a short period.

Unfortunately, most conflict lasts for years, resulting in conditions that force displaced people to remain in their host countries for extended periods of time.

Responsibility of the Health Worker

It is the role of health workers to act (within a legal framework) as advocates for access to healthcare, and not to restrict or ration care. The ethical duty of a health worker is to treat patients in a manner that serves the patient's best interests.

Medical assistance should ensure the "right of everyone to the enjoyment of the highest attainable standard of physical and mental health" and must be offered without discrimination. People in need of healthcare should not be denied HIV treatment because of their nationality.

Medical Management

All people, including displaced persons, should be encouraged to regularly test for HIV. Re-testing should occur in all patients who report being HIV positive. This must be done with their informed consent. Counselling should be made available if results from re-testing are negative and confirmatory testing/ expert consultation sought. As is the case with the general population, people from displaced communities may present late with AIDS-defining illnesses, as well as for PEP and antenatal care. Advanced presentation is not a reason to deny care. Earlier diagnosis should be pursued at every opportunity. Displaced persons may be anxious that disclosure of their HIV

status will have implications for their residency, resettlement and other legal consequences. The reality is that HIV status does not have an impact on the legal status of a displaced person in the southern African region.

Despite this, displaced persons may be anxious about disclosing their HIV status. Some refugees may wish to remain anonymous for a myriad of reasons, including very real security concerns. It is up to the health worker to deliver care in a manner that does not put them or their families in danger. Health workers must reassure patients that their privacy and confidentiality in this regard will be respected. A full history, clinical, psychosocial and available laboratory evaluation should be done for all patients according to the national protocol.

Antiretroviral Therapy ART

ART is a lifesaving intervention. In principle, ART should be lifelong and thus sustainability should be key. However, even if sustainability is not guaranteed, immune reconstitution on ART, even for short periods, can yield significant clinical benefits. Furthermore, provision of ART is rapidly evolving in the region, and is increasingly accessible even in very poorly resourced areas. Hence, starting someone on ART for even a limited period of time may allow them to access more sustainable treatment at a later stage. There is substantial evidence however, that ART interruptions may be harmful, and this option must be carefully weighed and generally only considered in severe disease.

Adherence support needs of displaced persons may be very different from those of the local community. A displaced person may not have the traditional support of family or friends, although there may be strong cohesion among displaced communities who share similar reasons for displacement. As the circumstances of displaced persons often change without warning, assistance needs should be constantly

assessed, and appropriate counselling and support provided where necessary.

1.1 Initiation criteria for patients with no ART history

Patient preparedness

Patients must make an informed decision to begin and be adherent to ART. Proper counselling is key to ensuring the displaced person's understanding of these principles. Counselling in an appropriate language and with due regard for cultural differences is crucial. UNHCR has translation resources available for refugees.

Counselling should also take into consideration the particular background and human rights context of the displaced person. The possibility of treatment interruptions should they be further displaced must be specifically addressed during counselling, e.g. if they travel to a different area, they may need to find an alternative drug supply and HIV care network. The possibility of interruption should not be used by the health worker as a reason to deny access to care. Instead, strategies should be explored with the displaced person to find solutions.

In the event of informed refusal of ART, as with any other patient, continued counselling is required. Furthermore, access to other interventions including prophylaxis and treatment of opportunistic infections should not be withheld.

Country-specific exclusion criteria for ART

These criteria should be viewed very critically, taking into consideration the specific circumstances of displaced persons. Certain criteria may need to be modified to include displaced persons in ART programmes. For example, some programmes ask for a 'treatment buddy', which can be a challenge for displaced persons who are often alone or separated from traditional support structures. Imaginative solutions are usually available and

should be explored (see Solutions Box below).

Biological criteria for initiation of ART

National guidelines should be adhered to, where these are available. Where there are no national guidelines, World Health Organization (WHO) guidelines should be followed. The absence of laboratory facilities should not be used to exclude HIV infected people from treatment. For example, if a displaced person does not have access to or cannot afford CD4 testing at initiation, WHO guidelines clearly state that clinical staging is an acceptable indicator for ART initiation.

If return to country of origin or further movement is imminent

The following considerations should govern the decision to immediately commence ART:

- (i) ART is a lifesaving treatment and should be carefully evaluated in each case, regardless of whether return or further displacement is imminent.
- (ii) In many cases, the conditions and access to ART at the site being travelled to is unknown. Information may be out of date in many cases, especially as ART access has expanded so rapidly. Conflict may interrupt access to previously accessible health services. Displaced persons may therefore return to HIV care systems that are either stronger or weaker than they had anticipated.
- (iii) Stage of disease and anticipated availability of treatment at the site being travelled to should guide the urgency of initiation.
- (iv) If patients have advanced clinical disease (severe AIDS-defining disease or a low CD4 count (<50 cells/ul), they should be advised to delay their departure and ART commenced immediately. However, clinical discretion is required in all cases.
- (v) If the patient is WHO stage 3 or healthy, with a good CD4 count (if

available) and

- treatment is available at the site being travelled to: The site of initiation (either at the current health site, or at the receiving site) should be determined by the following factors: timing of departure, duration of travel, ART regimen at the receiving site (if known), anticipated side-effects and conditions on arrival (e.g. local waiting time to access ART). All these need to be discussed with the patient so an informed decision can be made.
- treatment is NOT available at the site being travelled to: The displaced person should be encouraged to remain where they are and initiate ART for at least 3 months to monitor potential side-effects and adherence, and subsequently be provided with a stock of medication for 3-6 months if possible.
- individual insists on leaving immediately or in the near future: These individuals must receive comprehensive advice on options available (see below). All should be considered suboptimal.

Options include:

- (a) leaving with no ART,
- (b) initiation for a short period prior to leaving together with additional ART stock,
- (c) leaving with a supply to be initiated at the receiving site (with referral letters and extensive pre-adherence counselling). The guidelines group felt that option (b) and (c) were dangerous, and should only be considered in exceptional circumstances. In many situations, the person will be going to an area with poor or limited health care, food insecurity, limited or no access to clean water or accommodation. In this situation, option (a) may be more appropriate. For other individuals who are going to better

conditions and have a good understanding of HIV and ART, options (b) and (c) may be considered if this is the only option.

Consequences of initiating ART in the (b) and (c) scenarios may include developing side effects in an unsupported environment, possible development of ART resistance due to the lack of adherence support, and the difficulties of initiating and maintaining treatment during a stressful and unstructured time. These consequences must be fully explained to the patient.

- (vi) There may be additional reasons for delaying treatment initiation, other than those listed above, such as patient readiness, practical considerations (such as side effects during travel and reintegration), concurrent medical conditions that may worsen on ART (e.g. immune reconstitution diseases may present catastrophically and the receiving site may not have the resources to manage them); and other considerations.

The risks and benefits of deferring treatment must be carefully weighed against immediate initiation; options should be discussed with the patient, including delaying departure.

- (vii) This decision-making may require significant ART expertise, and the health worker should consult if s/he is not confident about their level of expertise.
- (viii) Choice of regimen: In general, try to match the regimen to the one the individual is most likely to be on over the next year. If return or displacement is likely to be soon, try wherever possible to match the regimen to what is available in the patient's new area of residence.

SOLUTIONS BOX: Solutions to problems encountered when initiating patients on ART

Problems	Solutions
CD4 count is unavailable or unaffordable	WHO clinical staging is simple, and relatively sensitive and specific
Treatment buddy is required by national guidelines	Use a friend, companion, family member, support group, local health worker, or local faith-based or non-governmental organisation (NGO) member
Language barriers between counsellor and patient	Contact UNHCR for list of translators
Payment, lab costs, transport costs are an obstacle	Displaced persons must be assisted with a waiver process if one exists; others can be referred to NGOs and social welfare organisations. Refugees can be referred to UNHCR
Geographical exclusion criteria exists, but patient is unable to return to home site	If outside the treatment catchment area, patient must demonstrate ability to regularly attend appointments and then assisted to negotiate for inclusion with the relevant authorities

1.2 Patient presents on ART or with history of previously taking ART

In circumstances where the displaced person is either currently on ART, or has a history of previously being on ART, the following is recommended:

- A repeat HIV test to confirm their infection.
- If the individual is currently on ART, continue treatment with no interruption.
- If possible, a viral load and CD4 count should be done at the time of the first visit. If the viral load is raised (according to the national protocol), adherence intensification is usually warranted. Expert opinion should be sought before ordering resistance testing, if available.
- If there has been a treatment interruption, try to restart treatment as soon as possible, after careful assessment of the reasons for the interruption (see below). The viral load may be high if the interruption is significant.
- Adherence counselling and support

should be undertaken in light of the new circumstances.

Choice of regimen if currently on ART

In general, most patients in sub-Saharan Africa are currently initiated on d4T or AZT, 3TC and a non-nucleoside reverse transcriptase inhibitor (NNRTI), either nevirapine or efavirenz.

- If on same regimen as national programme:
 - Continue same regimen.
- If on different regimen from national programme:
 - If the national guideline supports the different regimen, continue with this regimen and initiate monitoring according to the local algorithm. Occasionally, the national regimen protocols may offer better treatment options, or new treatment options may become available, and these cases should be assessed with suitable expertise.
 - If the national guideline does not support the regimen, the following possibilities should be considered, as they may not allow patients to go on the regimen

indicated under the national protocol:

- ▢ history of side-effects and comorbidities
- ▢ history of possible virological, immunological or clinical failure
- ▢ use of concomitant medication

In this case, select the best available regimen from available drugs.

If on unknown regimen, with minimal history

In general, these patients should be initiated on the national guideline's first line therapy, and followed closely. Where possible, a viral load after 6 weeks of treatment should be used to indicate efficacy and a significant drop in viral load (1-log) should be anticipated if the regimen remains effective.

Choice of regimen if ART was interrupted

Establish the cause of the interruption. Note that displaced persons are at greater likelihood of treatment interruption due to factors beyond their control, e.g. conflict resulting in displacement from their normal ART site.

"They saved my life." - Migrant in Johannesburg on ART through faith-based organisation

Routine evaluation:

- ▢ If adherence is an issue, this needs to be explored. However, there is no evidence that displaced persons are less adherent than local populations.
- ▢ If virological failure was the reason, treat as per national protocols, which may mean accessing second line regimens, if available.
- ▢ Subsequent drug choices should be carefully evaluated in the case of adverse side effects.
- ▢ If interruption was due to drug supply issues, and there were no adherence, resistance or toxicity issues then ART should be reinitiated as soon as possible
- ▢ If the previous regimen was the

same as the national programme, restart ART. Nevirapine deserves special consideration in the event of the patient having a high CD4 count, as it is associated with significantly increased toxicity. If nevirapine is restarted after an interruption of >1 week, recommence with the 2 week lead-in dose, and monitor alanine transaminase closely for the first 3 months of treatment (if laboratory monitoring is available).

If the previous regimen is different from the current recommended regimen, considerations should be as above.

1.3 Contingency planning

Displaced persons can be affected by unforeseen events, causing them to move unexpectedly. This needs to be explored at every visit. Discuss the provision of a personal ART stock where necessary (2-4 weeks will allow for time to make alternative plans for ART access).

All patients should have a clinical HIV summary, such as a treatment card, which includes their drug regimens, prior toxicity, illness history and laboratory results. All patients should also be aware of their basic medical history and be able to relate it verbally. This assists continuity of treatment in the event of unplanned displacement.

If on an NNRTI regimen (which have a long half-life) and treatment is stopped with no possibility of immediate restocking of drugs, consider covering the tail (the long half-life of NNRTIs) by continuing dual nucleosides for a week after stopping the NNRTI, to prevent possible NNRTI resistance.

In the event of unplanned displacement, patients should be cautioned on non-reputable sources of treatment, including counterfeit drugs, cheaper but less effective regimens (such as dual therapy), inconsistent sources of drugs, and poorly trained health worker

advice. They should be counselled to seek continued care only through a public or reputable programme.

Sharing of ART and dose reduction/interruption to extend the stock lifespan must be discouraged.

Mythbusters

'Resistance to ARVs is caused by suddenly stopping ART'

Stopping ART suddenly is rarely associated with resistance; poor dosing, poor drug quality and poor adherence are far more common causes. There is concern about stopping NNRTIs along with other classes of drugs, as they have a long half-life. This is discussed above.

'Access to monitoring is poor and hence ART should not be started'

If laboratory monitoring is not available, clinical monitoring, although sub-optimal, is sufficient to start ART.

'Access to guaranteed lifelong therapy is a reason not to start ART'

Treatment may allow a person to live long enough to access more sustainable sources of ART, especially as broader availability increases throughout the region. However, there are dangers in interrupting treatment, and this must be avoided wherever possible.

1.4 ART-specific challenges

The choice of ART should take the following into account:

- ▢ National guidelines should be used. Within this, try to match this regimen to the possible regimen in the area being travelled to, if travel is anticipated soon.
- ▢ Some ARVs (e.g. ritonavir) require refrigeration. Assess availability of refrigeration during travel and at the receiving site; and adapt ART accordingly.
- ▢ Some ARVs require food intake for optimal absorption. Many regimens require twice daily dosing.

- ▣ Displaced persons may not have sufficient food available and should be told to take their medications despite lack of food, and warned of possible increased gastrointestinal side-effects. At the same time, food aid should be sought for these persons.
- ▣ In many cases, patients may be on fixed-dose combinations (FDCs) in their prior ART site, and this may mean a higher pill burden in their new site if the FDC is not available. The changes should be carefully explained during adherence counselling.
- ▣ If the ART choice requires more frequent monitoring, consider the ease and cost of access to the displaced person. As with local populations, transport costs are often a barrier to regular visits.
- ▣ ARVs requiring reconstitution (some paediatric formulations) depend on access to clean water, which may not be easily available to displaced persons.
- ▣ The absence of access to laboratory monitoring (either due to lack of facilities or cost) in the current or receiving sites, should not be used to exclude people from ART. Minimum standards for laboratory monitoring are outlined in the WHO and national guidelines, and should be adapted as much as possible to enable access. If the ART choice requires more frequent monitoring, consider ease and cost of access. For example, a nevirapine regimen should ideally have liver function monitoring in the initiation phase, which may increase the frequency and cost of visits. However, in many cases, nevirapine is the only NNRTI available, and no liver function testing is available, in which case the drug should be initiated with extensive patient counselling.

1.5 Management of children

Initiation of treatment should be based

on national guidelines. In certain cases, if diagnostic and monitoring facilities are not available, refer to the WHO guidelines for HIV diagnosis that is based on a positive HIV antibody test and clinical findings.

Syrup formulations have large volumes, and can be difficult to carry and refrigerate. This may be particularly relevant to those travelling long distances and should be taken into consideration when making clinical decisions.

In children <18 months who are diagnosed clinically, parents should be counselled to seek confirmatory testing after 18 months of age with conventional antibody tests. This is particularly important where further displacement is possible.

Unaccompanied minors are a special issue, and may need to follow a special legal process or agreed upon guardian/caregiver arrangements. These need to be expedited as quickly as possible, so as not to delay ART. For refugee children, contact UNHCR for assistance.

1.6 Post-exposure prophylaxis (PEP)

In populations affected by conflict, gender based violence and assault is common throughout the cycle of displacement.

Sexual exploitation is also common among female migrants, who can be victims of trafficking. PEP should be considered for displaced persons in need; however, assessment often takes place after the efficacy of PEP has passed.

PEP includes HIV, sexually transmitted disease and pregnancy prevention. Trauma and adherence counselling is essential in all cases.

National and WHO/UNHCR^{vii} PEP guidelines should be followed. If

national guidelines exclude displaced persons, treatment should be accessed wherever possible (e.g. from rape crisis centres, NGOs, faith-based organisations, private practitioners). For refugees who cannot access PEP through a local service, contact UNHCR urgently.

1.7 Prevention of mother to child transmission (PMTCT)

PMTCT services may not be available in the prior site; and hence women may not have been counselled regarding PMTCT.

Pregnant women may require counselling on testing, treatment and feeding options available in the host health care environment.

In cases of moving to sites with unknown or poor access to care, similar to treatment for tuberculosis in pregnancy, the pregnant woman and her family should be advised to delay moving until after delivery in order to complete the PMTCT programme. In cases of moving to sites with established PMTCT programmes, the patient should be advised to immediately seek out local PMTCT programmes on arrival. However, due consideration to the stage of pregnancy, duration/mode of travel and conditions on arrival must be discussed. A clear referral letter is important at all times, in both the antenatal and postnatal period.

Provision of PMTCT drugs to pregnant women about to move should be considered in the event of labour occurring en route; or the patient arrives in an area where there is no PMTCT programme. Take note of the considerations described in the section that deals with individuals in need of ART who are facing imminent departure (see section 1.1 Initiation Criteria for patients with no ART history > If return to country of origin or further movement is imminent) to counsel appropriately.

Non-ART considerations

2.1 Tuberculosis (TB) treatment, and primary and secondary prophylaxis for opportunistic infections including cotrimoxazole, fluconazole and isoniazid

National guidelines should be followed. Interruption of prophylaxis should be avoided through rapid referral to local sites providing these drugs. People with TB should be encouraged to complete TB treatment before further movement.

Cotrimoxazole demonstrates significant benefit in areas affected by malaria and bacterial infections, as well as in people with WHO stage 2,3 and 4 disease. Cotrimoxazole should be strongly considered, in line with national and WHO guidelines. A contingency stock of prophylactic medications, as for ART, is recommended for people at risk of unplanned movement (2-4 weeks supply).

2.2 Other illnesses

Malaria is extremely common in the region, but typhoid, trypanosomiasis, viral hepatitis, cholera, amoebiasis, measles and other diseases that can affect travellers should be considered, and appropriate prevention advice given. Be aware of other countries' endemic AIDS defining diseases that may not be common in the host country (e.g. kala-azar in Somalia, histoplasmosis in Zimbabwe).

2.3 Language

Using family members or community members as interpreters carries risks regarding respect for confidentiality and inappropriate disclosure, and should be avoided where possible. Furthermore, information may be less forthcoming through a third party if the party is known to the person. All efforts should be made to have an independent interpreter who has been trained in issues of confidentiality.

Ongoing adherence counselling is a

challenge if an interpreter is not readily available.

Do not refer refugees to their country's embassy, as that may jeopardise their asylum status. This may be an option, though, for other displaced persons e.g. economic migrants.

For help with language barriers, contact UNHCR who may be able to identify suitable interpreters.

2.4 Referral letter

Note that due to language issues, the health worker at the distant site may not speak or read the referring site's language, and may not be able to read the referral letter or treatment card of the referring site. Use generic names and terms such as stavudine, tuberculosis, cryptococcal meningitis and internationally agreed upon abbreviations or acronyms such as PMTCT or VCT (voluntary counselling and testing). Referral letters may get lost, therefore explain the contents of the letter to the patient, so they can relay information verbally if necessary.

Other important issues

3.1 Cultural issues

The background and culture of a displaced person may be different to that of the host country. Health workers should be culturally sensitive and non-judgemental. Regardless of cultural traditions or practices, the health worker should maintain professional standards and practices, although this may require additional time and effort. For example, if a man insists on knowing the HIV test results of his spouse without her consent, as this is his 'right' according to his culture, a more detailed explanation of the principles of confidentiality and disclosure may be required.

3.2 Alternative treatments

As with many local communities, displaced persons may seek alternative treatments. Encourage them to share

this information with the health worker, so that informed treatment decisions can be made. In almost all cases, drug interactions between ART and alternative medications are unknown, and should be discouraged where possible.

3.3 Psychosocial and mental health

Displaced persons, particularly those coming from conflict areas, may have experienced trauma and violence, including sexual violence, and therefore may need specific psychosocial support. These issues should be explored sensitively and efforts to refer to specialised services should be made.

History taking may provoke anxiety, depression and stress responses. Appropriate counselling should be made available.

3.4 Prevention

Southern Africa is an area of very high HIV prevalence. In some cases, displaced persons will be moving into a high risk or higher prevalence environment (e.g. from Somalia to South Africa). Displaced persons should be made aware of increased HIV risk. Some populations have very limited knowledge of prevention methods, such as condoms, and health workers must not assume core knowledge exists.

For those already living with HIV, prevention messages must be re-emphasised to avoid further infections. Prevention messages, verbal or written, must be communicated where possible in the displaced person's language. The essential linkage between prevention and treatment is as relevant in this situation as with the host general population.

3.5 Reproductive health

Family planning availability needs to be carefully explained. Issues such as access to contraception, termination of pregnancy, emergency contraception and availability of ante/postnatal care

should be outlined for all displaced persons.

Specific care options may not be known to the person due to unavailability in area of origin (e.g. contraceptive methods, pap smears); these new options should be explained.

3.6 Gender-based exploitation and violence

Sexual violence often accompanies conflict and consequent displacement.

Displaced persons are often economically vulnerable, and may be at increased risk of sexual exploitation and abuse. In particular, women and girls may be more susceptible to HIV infection due to gender discrimination and violence, insufficient access to HIV prevention information & services, inability to negotiate safer sex, and lack of female-controlled HIV prevention methods.

Information anticipating this, especially regarding PEP and psychosocial support, should be provided.

A careful and sensitive history should be taken in all cases. Where sexual assault has occurred, appropriate systematic care, support and treatment should be initiated, as per national guidelines.

3.7 Orphans, separated and vulnerable children

The nature of displacement often results in family separation. There may be an increase in orphans due to conflict and a related increase in communicable diseases. Displaced children may also be accompanied by a relative or another adult who is not a relative. If there are any concerns regarding the guardianship or care arrangements for the child, refer directly to social services for assessment. Specialised counselling may be required for these children.

Red Cross/Red Crescent and other

organisations facilitate tracing of family members and the return of children to their country of origin.

Consent issues are covered in the paediatric treatment section (see section 1.5 Management of children).

3.8 End-of-life care

Treatment options closer to the person's home may need to be explored in the event of limited mobility. Palliative care options vary, and support is often available in the host country through government programmes and NGOs. Refugees wishing to return to their country of origin should contact UNHCR.

3.9 Death and body disposal

Body transport across borders may be expensive, logistically complex and bureaucratic. International organisations rarely facilitate the transport of a body to the home country, although faith-based organisations may.

In the case of terminal patients, this information should be sensitively explained to the patient and their family members, and any available support offered.

Advocacy

Health workers should advocate for non-discriminatory medical practices, and must play an active role in reducing discriminatory attitudes and dispelling myths regarding displaced persons.

Concerning refugees and asylum seekers, many countries in southern Africa, such as Namibia, South Africa and Zambia, have specific policies that include these groups in their public sector ART programmes. Others, such as Mozambique, Malawi and Zimbabwe do not specifically exclude refugees or asylum seekers from public sector ART. As at March 2007, Botswana is the only country with a policy that specifically excludes non-nationals from the ART programme.

However, UNHCR and other organisations are advocating the government to lift this restriction.

Where policy restrictions exist, precluding ART access in the public sector, migrants, refugees and others should be referred to either NGO, faith-based or private sector ART programmes.

References, case studies, a list of the key documents and the members of the guidelines committee and notes to the guidelines are available on the website www.sahivsoc.org

Displaced populations
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Nurse's role in the Management of HIV Services

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Nurses play an essential role in the management of HIV services. This article reflects on getting nurses more engaged in management through research and capacity development

The “Strengthening Nurses’ Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean” research programme, is entering its final six months of an intensive participatory action research (PAR) process and capacity-building programme of research. The programme of research extends over five-years and involves Canada and four partner countries, i.e. Kenya, Jamaica, Uganda, and South Africa. The aim of this multidisciplinary programme of research is to strengthen the health systems for specifically, though not limited to, HIV and AIDS in Sub-Saharan Africa and the Caribbean (Klopper, et al., 2011). The aim is supported by improving the quality of HIV and AIDS nursing care, supporting the scaling-up of innovative HIV and AIDS programmes and practices, and fostering dynamic and sustained engagement of researchers and research users in the policy development process (Edwards et al, 2007). In achieving these goals a critical strategy provides a platform for developing research and leadership capacity among nurses and midwives.

Embedded in the strategy, is measuring the impact of the research intervention called the “leadership hubs”, which was established in each of the three intervention district within the four participating countries. In South Africa specifically these three districts were established within the North-West province. These hubs consist of front-line nurses and managers, researchers, decision makers, and community representatives to promote dynamic engagement and sustained collaboration within and across countries on HIV and AIDS research, health services programmes and policies. They are intended to function as levers for health systems change (Year Four Progress Report, 2011:6) with an anticipated direct impact on how HIV services are managed by nurses at the primary health care level.

Objectives of the programme of research

In achieving the aim as highlighted above, the programme of research and capacity development proposed

two research specific objectives and four capacity building and knowledge translation objectives. These objectives are:

Research objectives

- To examine the dynamic interplay of multi-level factors that influence nurses’ engagement in strengthening health care systems for HIV and AIDS in lower and middle income countries (LMICs), and
- To determine the impact of leadership hubs and a participatory action research process on nursing care and workplace policies for HIV and AIDS.

Capacity-building and knowledge translations objectives

- To promote on-going, long-term, interactive dialogue and collaboration among front-line nurses and managers, researchers, decision makers including physicians, and community representatives on HIV and AIDS research, health services programs and policies
- To strengthen the capacity of selected academic institutions and research-user groups to support and participate in nurse-led research that is highly relevant to health services and policy decision-makers
- To integrate best practices for knowledge translation into the work of nurses in senior academic, clinical, government and non-governmental organization (NGO) positions, and
- To implement a mentorship program that supports nurses to do and use research in response to key policy issues related to the provision of HIV and AIDS services.

From these objectives it is evident that the collaborative international research team strongly support the role of the nurse in the management of HIV services. Based on this position, for HIV services (prevention, treatment and care) to improve in LMIC, nurses play a pivotal part and they should be

included in all relevant research and development initiatives to ensure an understanding and improve the current HIV service needs.

Research method

In order to gain a better understanding of the management of HIV services in the participating countries the research team investigated the current clinical practices of frontline nurses and nurse managers, the human resource policies in the institutions giving these services and also the current impact of HIV on the nursing workforce.

A random sample of 157 registered nurses and midwives completed a questionnaire on stigma (Year Four Progress Report, 2011:6iii), followed by a random sample of 44 nurses, midwives, nurse managers and administrators that completed the Human Resource Management Rapid Assessment questionnaire for HIV and AIDS Environments (Year Four Progress Report, 2011:6iii), along with 12 qualitative face to face interviews with individuals from the same sample to explore current workplace policies on HIV and AIDS (Year Four Progress Report, 2011:6iii). We furthermore conducted 42 qualitative face to face interviews and 3 focus groups with professional nurses, nurse managers and midwives (Year Four Progress Report, 2011:6iii).

Results of current management of HIV services

Here are some highlights on the preliminary findings within the programme of research.

Current clinical practices of frontline nurses and nurse managers

Over 95% of nurses and midwives reported the use of universal precautions among patients with HIV and AIDS most or all of the time. Other patient needs were consistently assessed less often. And only 53% of respondents reported assessing patients’ comfort disclosing their HIV status to family members most or all of the time (figure 1). Policies and procedures were in

place to support these practices in over 90% of health care settings (figure 2). There were however, some nurses and midwives who did not know if quality assurance programs existed in their organization and furthermore only 42.20% of these nurses and midwives reported referring patients most or all of the time (figure 1). Interestingly is that nurses and midwives working in health centres are significantly more likely to address the needs of the families of patients living with HIV and

AIDS than nurses and midwives working in district and provincial hospitals.

Current human resource policies at the health care centres

The overall responses in relation to the five different human resource components (table 1) clearly emphasises a human resource management policy gap as most of the participants viewed current policies as "Policies weak or not properly enforced". The team also

learned from the interviews that though most of the participants highlighted the current human resource management policies as being weak and/or not properly enforced, it could be due to employees not being aware of all the current policies and/or how to use them. The findings in relation to the policy gap identified are also very relevant at the different levels of health care facilities.

Current impact of HIV on the nursing workforce

Frontlines nurses and nurse managers emphasized both negative and positive ways in which HIV has impacted their work environment. Almost all of the participants described increased workloads due to HIV and AIDS as the biggest problem in all health care institutions. This is due to the increased numbers of very ill patients living with HIV and AIDS. Accompanying the increased workload is the shortage of frontline nurses and inevitably resulting in burnout of those nurses working at the health care institutions. The notion of burnout of nurses was supported by almost all the participating nurses in South Africa. The nurses furthermore argued burnout as having the biggest impact on not only the quality of nursing care rendered by nurses and midwives but also the cause of family breakdowns of these nurses and midwives.

Figure 1: Five aspects of registered nurses and midwives own clinical practices regarding HIV and AIDS (n=157)

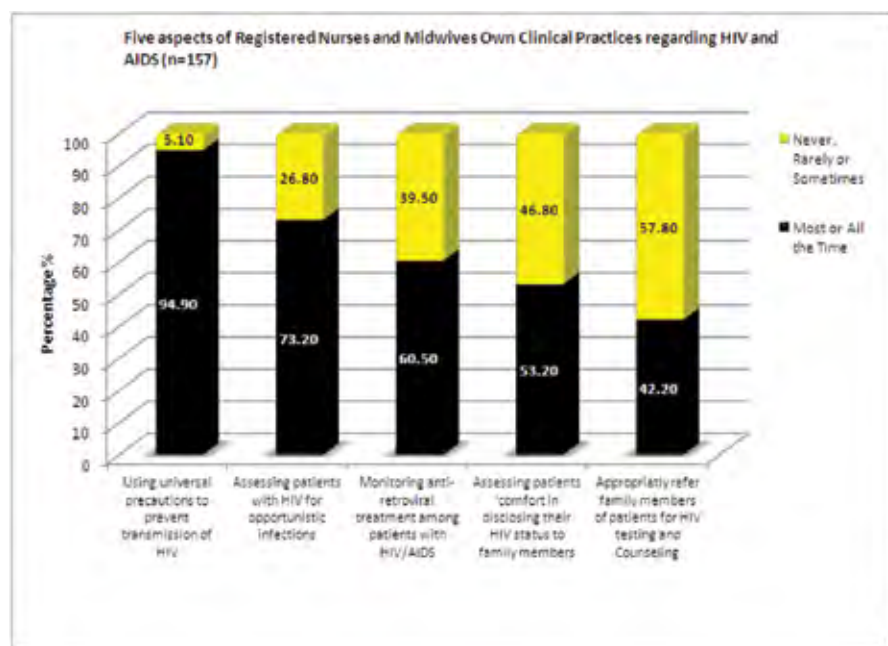
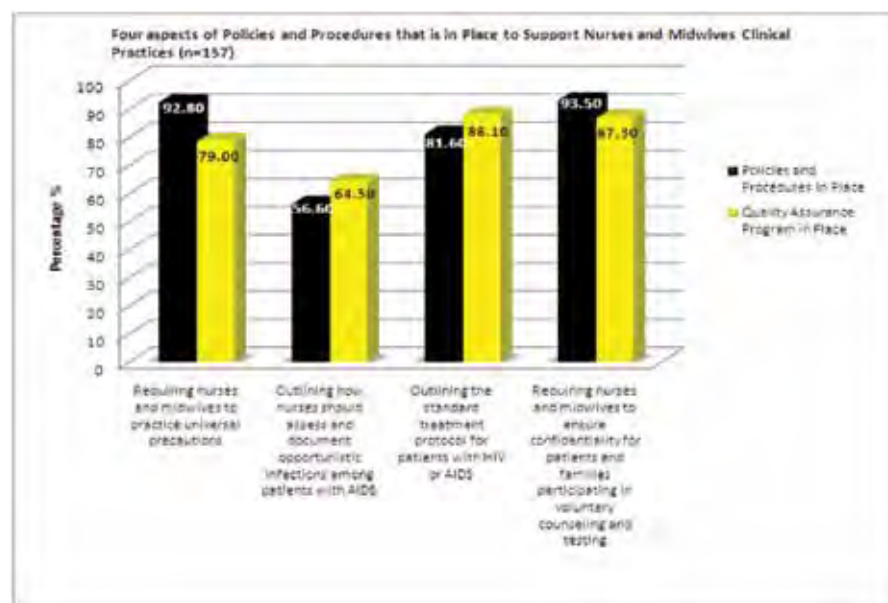


Figure 2: Four aspects of policies and procedures that is in place to support nurses and midwives clinical practices (n=157)



Some of the positive aspects mentioned were: a.) increased opportunities for continuing education and training in HIV and AIDS care; b.) enhanced nursing capacity to manage HIV and AIDS; c.) increased awareness of standards and procedures in infection control and d.) partnerships with Non Governmental Organizations (NGO) in HIV and AIDS care

Stigma as an influence on the effective management of HIV services

Stigma has a great influence particularly for those individuals living with HIV and AIDS as it contributes to the failure to test, non-disclosure of HIV status including keeping their status secret from their families, and non adherence

Table 1: Responses to the five human resource management components (n=44)

Five human resource management components	No policies in place	Policies weak or not properly enforced	Policies in place and enforced
Human resource management capacity (3 items)	19%	52.8%	28%
Personnel policies (12 items)	18.5%	43.5%	38%
Performance management (5 items)	10.6%	47.2%	42.2%
Training (4 items)	15.9%	51.2%	32.9%
Human resource management data (2 items)	9.2%	49.4%	41.4%

to treatment which in return results in many severely ill patients being admitted in health care institutions in the late stages of the disease.

Nurses and midwives more frequently described occurrences of being stigmatized than stigmatizing patients with HIV and AIDS. There were no differences in the patterns of being stigmatized across level of facility.

highlights and serves as an illustration on the current management of HIV services. This is typically areas that are deduced from the research results that nurses can act on. By "act on" the intention is that the LH's - as research intervention - in collaboration with local health care institutions develop actions/initiatives in addressing the current challenges experienced in the management of HIV services.

of both the national and international research team, the LH's developed initiatives to influencing practice (see table 3). The LH members are actively involved with these activities in their different districts.

Over and above the activities currently in progress, there are also activities planned in the near future that will focus on the development of LH's

Table 2: Capacity development topics covered by the LH members

Capacity development topics covered by the LH members	
Research related	<ul style="list-style-type: none"> • The basics of research • Doing a literature review • What is evaluation?
Knowledge Translation	<ul style="list-style-type: none"> • Knowledge translation in Nursing
Evidence-based practice	<ul style="list-style-type: none"> • Evidence-based practice in Nursing
Policy Development	<ul style="list-style-type: none"> • Policy development with a emphasis on the policy cycle and how to influence policy
Networking	<ul style="list-style-type: none"> • Context mapping
Project Management	<ul style="list-style-type: none"> • Developing a Evaluation project • Developing of a communication plan • Developing a project work plan • Developing a risk plan • Developing of a project budget
Personal Development	<ul style="list-style-type: none"> • Leadership

Interestingly, nurses were significantly more likely to report stigmatizing patients in district hospitals than in the provincial hospital or in health centres.

Nurse lead knowledge translation on research findings

Structuring of an intervention, based on the research findings is a crucial part of the programme as it supports the nurses in taking action. Keeping in mind the findings reported are

Over the past two and a half years the LH's members attended and participated in numerous capacity development sessions. The topics covered at these sessions are presented in Table 2.

Part of the overall aim of developing the LH's members the focus was also to prepare the LH's members for taking action, specifically related to improving the current management of HIV services in the participating health care institutions. Through the mentorship

members skills in making use of media in communicating findings, and training LH's in developing and writing up of policies' briefs.

Conclusion

To effectively manage HIV services in LMIC's it would be a critical mistake to view the nurses' role as merely that of a workforce issue. Nurses can and must play a larger role on higher levels of health care where they can provide

Table 3: Initiatives developed with the aim of influencing HIV service management practice

Initiatives developed with the aim of influencing HIV service management practice	
Initiative	Brief description
Evaluation Project	Evaluation of the follow-up of patients on anti-retroviral therapy (art) in the North West province, South Africa.
Sharing of findings	Communiqués': up to date three communiqués have been compiled and is in process of being shared by the LH's with the relevant stakeholders in their districts. These communiqués are: Health Care Workers Experience of Health Human Resource Policies HIV and AIDS Clinical Practices of Nurses in South Africa Nurses' Experience of Stigmatization in HIV and AIDS Care. Formal and Informal presentations by LH members at their different constituencies and with relevant stakeholders in their districts.
LH Action plan	LH members have identified several actions they would like to take in reference with the findings. One of these actions that stand out in all three the districts is the policies' gaps that the hubs members would like to address by holding in-service training session at the different health care institutions.
Case Studies	Case studies have been developed as in-services training at the different health care institutions and focuses on practice related challenges. As identified by the nurses and also from the research findings.
Leadership Hub Website	The international research team is launching the International Leadership Hub Website within the next month. The website will serve as a great resource for the LH members to share resources, ideas and advice and related issues.

informed information regarding the policies developed and decisions made for advancements in the management of HIV services. Nurses must also be more involved in policy development especially if those policies relate to how they should manage HIV services at a primary level and importantly nurses must be developed and supported in taking up leadership roles in the fight against HIV and AIDS.

Furthermore nurses should actively engage in an awareness and understanding of the current internal and external influences that's having an impact on their work environment. They should be more involved in research initiatives and more actively participate in collaborative initiatives on both national and international level to ensure they know about and adhere to the best available clinical practice guidelines and standards.



References

1. Klopper, H.C., Watson, F.G., Muller, C.E., Edwards, N., Kasege., & Kahwa, E. (2011). Nurse leadership development over continents. *HIV Nursing Matters*, 2(2):28-33, June.
2. Edwards, N., Kahwa, E., Kaseje, D., Mill, J., Webber, J., & Roelofs, S. (2007). Strengthening health care systems for HIV and AIDS in Sub-Saharan Africa and the Caribbean: A program of research. *Caribbean Journal of Nursing and Midwifery*, 2, 29-36.
3. Year four progress report February 1, 2010 to January 31, 2011. (2011). Strengthening Nurses' Capacity in HIV Policy Development in Sub-Saharan Africa and the Caribbean. IRDC Grant number: 103460-042. Submitted to IDRC on March 24, 2011 by University of Ottawa, Canada

Nurses are essential roleplayers in the management of HIV services and the strengthening of health systems

Toll-Free National HIV & TB Health Care Worker Hotline

Are you a doctor, nurse or pharmacist?

Do you need clinical assistance with the treatment of your HIV or TB patients?

Contact the TOLL-FREE National HIV & TB Health Care Worker Hotline



**0800 212 506 /
021 406 6782**

Alternatively send an SMS or
"Please Call Me" to 071 840 1572
www.hivhotline.uct.ac.za



The Medicines Information Centre (MIC) situated within the Division of Clinical Pharmacology, Department of Medicine at the University of Cape Town is the largest and only clinically-based medicine information centre in South Africa.

In collaboration with the Foundation for Professional Development and USAID/PEPFAR, the MIC provides a toll-free national HIV & TB hotline to all health care workers in South Africa for patient treatment related enquiries.

What questions can you ask?

The toll-free national HIV & TB health care worker hotline provides information on queries relating to:

- HIV testing
- Post exposure prophylaxis: health care workers and sexual assault victims
- Management of HIV in pregnancy, and prevention of mother-to-child transmission
- Antiretroviral Therapy
 - When to initiate
 - Treatment selection
 - Recommendations for laboratory and clinical monitoring
 - How to interpret and respond to laboratory results
 - Management of adverse events
- Drug interactions
- Treatment and prophylaxis of opportunistic infections

- Drug availability
- Adherence support
- Management of tuberculosis and its problems

When is this free service available?

The hotline operates from Mondays to Fridays 8.30am – 4.30pm.

Who answers the questions?

The centre is staffed by specially-trained drug information pharmacists who share 50 years of drug information experience between them. They have direct access to:

- The latest information databases and reference sources
- The clinical expertise of consultants at the University of Cape Town's Faculty of Health Sciences, Groote Schuur Hospital and the Red Cross War Memorial Children's Hospital



**MEDICINES
INFORMATION
CENTRE**



Call us - we will gladly assist you! This service is free.

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INITIATING ANTIRETROVIRALS IN SPECIAL PATIENT GROUPS



Patients with a low haemoglobin

The normal haemoglobin (Hb) concentration for adult males is 13.5–17.5 g/dL and for females 11.5–16 g/dL. It is important to have a baseline Hb for all patients starting zidovudine (AZT). AZT is haematologically toxic and can result in anaemia and neutropaenia, but not thrombocytopaenia (it usually increases the platelet count).

If the patient's Hb is less than 8g/dL,

refer to a doctor.

Patients with a high alanine aminotransferase

Before initiating nevirapine a baseline alanine aminotransferase must be done. The normal alanine aminotransferase (ALT) concentration range is between 5–40 IU/L. If the baseline ALT is elevated it is necessary to exclude hepatitis B co-infection by doing a hepatitis B surface antigen (HepBSAg) test. If the ALT result is above 100,

avoid nevirapine if possible. If you have no alternative to nevirapine, the ALT should be monitored closely for the first two months.

Patients with Hepatitis B co-infection

Chronic hepatitis B virus (HBV) is endemic in sub-Saharan Africa where prevalence is between 0.3–15%. HIV infection adversely affects the course of HBV in co-infected patients. HIV-HBV co-infection rates, based on

HBsAg-positivity, varies from 5–17% in different areas of South Africa. ¹

HIV-HBV co-infected patients should start ART containing two agents with anti-HBV activity, namely tenofovir plus lamivudine or emtricitabine, in addition to a non-nucleoside reverse transcriptase inhibitor (NNRTI) or protease inhibitor (PI). ¹

If possible, nevirapine should be avoided in those patients due to its potential for causing hepatotoxicity.

Tenofovir (TDF) and lamivudine (3TC) or emtricitabine (FTC) should be stopped only if they cause adverse effects severe enough to contraindicate their use, as stopping them may result in a hepatitis flare.

Before changing any patient from a TDF-containing ARV regimen, their hepatitis B status should be checked. If the patient is infected, TDF and 3TC or FTC should be continued along with the other drugs in the second-line regimen to prevent a hepatitis B flare.

Patients with a serum creatinine > 100 µmol/L

If your patient's serum creatinine is greater than 100 µmol/L and the laboratory has not calculated an estimated glomerular filtration rate (eGFR), it is essential to calculate the eGFR. Patients with an eGFR < 50 mL/min must not be started on TDF and should be referred for further investigation. Ensure that initiation of ART is not postponed for too long, as those patients may have HIV-induced renal dysfunction and therefore may benefit from ARVs.

Patients with an eGFR < 50 mL/min

Refer the patient if their estimated creatinine clearance is less than 50 mL/min. If referral is not available, start AZT + 3TC + efavirenz (EFV)/nevirapine (NEV). Remember to adjust the doses of AZT and 3TC according to the eGFR.

Patients with tuberculosis

Rifampicin, which is the most important TB drug, increases the rate at which many drugs are broken down by the body (metabolised). There is no significant effect on the metabolism of either the nucleoside reverse transcriptase inhibitors (e.g. AZT, TDF, 3TC) or efavirenz. Nevirapine is moderately reduced and the protease inhibitors (e.g. lopinavir+ritonavir) are dramatically reduced. Therefore patients requiring TB treatment including rifampicin should preferably be on a first-line regimen with efavirenz.

If efavirenz is contraindicated or not tolerated, use NVP and do not use the lead-in dose, but immediately give 200 mg twice daily.

Remember to increase the dose of lopinavir/ritonavir (LPV/r) appropriately in children and adults who are on rifampicin. **Adults** receiving concomitant rifampicin and LPV/r should have the LPV/r dose slowly doubled over two weeks to 800/200 mg twice daily. Monitor ALT monthly while on double dose and remember to reduce the dose to normal once the patient discontinues rifampicin. In **children**, additional ritonavir solution should be added at a dose of 0.75 x the lopinavir content of the LPV/r dose.

Streptomycin should not be given at the same time as tenofovir as they are both nephrotoxic. Therefore if a patient is on streptomycin treatment it is better to start either d4T or AZT rather than TDF – after the streptomycin has finished TDF can be used provided the creatinine clearance is > 50.

Women of childbearing age

Efavirenz is considered teratogenic and, as a result, nevirapine is the drug of choice in women of childbearing age who are not on reliable contraception. There are potentially important drug interactions with protease inhibitors or the NNRTIs and combined oral

contraceptives, resulting in alteration in the hormone concentrations.

There are limited data on the contraceptive efficacy of hormonal agents with ARVs, but depot progesterone injections and high dose combined oral contraceptive pills (COCP) will probably be effective when used with either nevirapine or lopinavir+ritonavir. Low dose COCP should be used with efavirenz as it inhibits the metabolism of oestrogen. Barrier methods should always be used in conjunction with hormonal contraceptives.

There is insufficient data on progestogen-only pills and patches to make a recommendation. ¹

If patients fall pregnant on efavirenz and this is only discovered during the second or third trimester of pregnancy, it is not necessary to change the efavirenz to an alternative agent. Close monitoring of the fetus is however recommended if first trimester exposure has occurred.

R

Reference:

1. AFA Clinical Guidelines 2010/2011



NDOH/SANAC Nerve Centre Hotlines

• Any HCT concerns from facility and district managers should be reported to the NDOH/SANAC

Nerve Centre Hotline and, specific emails for each province:

- **Western Cape:** 012-395 9081
sanacwesterncape@gmail.com
- **Northern Cape:** 012-395 9090
sanacnortherncape@gmail.com
- **Eastern Cape:** 012-395 9079
sanaceasterncape@gmail.com
- **KZN:** 012-395 9089
sanackzn@gmail.com
- **Free State:** 012-395 9079
sanacfreestate@gmail.com
- **Mpumalanga:** 012-395 9087
sanacmpumalanga@gmail.com
- **Gauteng:** 012-395 9078
sanacgauteng@gmail.com
- **Limpopo:** 012-395 9090
sanaclimpopo@gmail.com
- **North West:** 012-395 9088
sanacnorthwest@gmail.com



AIDS Helpline 0800 012 322

The National AIDS Helpline (0800-012-322) provides a confidential, anonymous 24-hour toll-free telephone counselling, information and referral service for those infected and affected by HIV and AIDS.

The helpline was initiated in 1991 and is a partnership of the Department of Health and **LifeLine Southern Africa**. The Helpline, manned by trained lay-counsellors, receives an average of 3,000 calls per day, and is seen as a leading telephone counselling service within the SADC region.

Services Offered by the AIDS Helpline:

- Information: The Line creates a free

and easy access point for information on HIV and AIDS to any member of the public, in all of the 11 official languages, at any time of the day or night.

- **Telephone Counselling:** Trained lay-counsellors offer more than mere facts to the caller. They are able to provide counselling to those battling to cope with all the emotional consequences of the pandemic.
- Referral Services: Both the South African Government and its NGO sector have created a large network of service points to provide a large range of services (including Voluntary Counselling and Testing, medical and social services) to the public. The AIDS Helpline will assist the caller to contact and use these facilities. The National AIDS Helpline works closely with the Southern African HIV Clinician's Society to update and maintain the **Karabo Referral Database**. www.sahivsoc.org
- **Treatment Line:** A specialised service of the AIDS Helpline, the Treatment Line, is manned by Professional Nurses. They provide quality, accurate and anonymous telephone information and/or education on antiretroviral, TB and STI treatment. They also provide relevant specialised medical referrals to individuals affected and infected by HIV and AIDS in South Africa.





**NATIONAL HEALTH
LABORATORY SERVICE**

RESULTS HOTLINE

0860

RESULT 737858

This line is dedicated to providing results nationally for HIV Viral Load, HIV DNA PCR and CD4 to Doctors and Medical Practitioners, improving efficiency in implementing ARV Treatment to HIV infected people. This service is currently available to members of Health Professionals Council of the South Africa and the South African Nursing Council. The hotline is available during office hours from 8am to 5pm Monday to Friday.

Register to use the RESULT HOTLINE

Follow this simple Step-by-step registration process

Dial the **HOTLINE** number **0860 RESULT (737858)**

Follow the voice prompts and select option 1 to register to use the hotline
A hotline registration form will be sent to you by fax or e-mail.

Complete the form and return it by fax or e-mail to the hotline to complete your registration process.

Once you are registered, you will be contacted with your unique number. This number is a security measure to ensure that the results are provided to an authorized user.

To use the hotline dial **0860 RESULT (737858)**

Select option 2 to access laboratory results.

- You will be asked for your HPCSA or SANC number by the operator.
- You will be asked for your Unique Number.
- Please quote the CCMT ARV request form tracking number (bar coded) and confirm that the result requested is for the correct patient.

Should the results not be available when you call, you will be provided with a query reference number which must be used when you follow up at a later date to obtain the result.

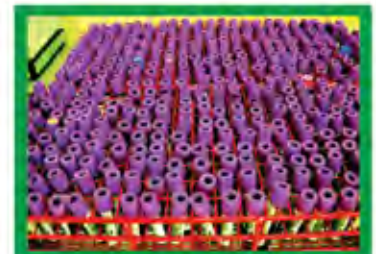
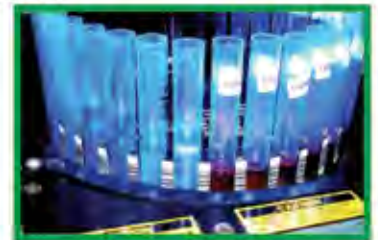
Once you have a Reference number

Select option 3 to follow up on a reference number

Should the requested results not be available, a query reference number will be provided to you.

A hotline operator will call you within 48 hours of receiving the laboratory results.

Registering for this service from the NHLS, will assist in improving efficiency, providing improved patient care and streamlining clinic processes. Call now and register to access results for HIV Viral Load, HIV DNA PCR and CD4.



Hospice Palliative Care Association of SA



Short Course in Palliative Nursing for Professional and Enrolled Nurses run in conjunction with the Hospice Palliative Care Association of SA and the Foundation of Professional Development.

INTRODUCTION

The WHO defines palliative care as "an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illness, through the prevention and relief of suffering, the early identification and impeccable assessment and treatment of pain and other problems, physical, psycho-social and spiritual."

Palliative care is an integral part of every nurse's role. This course equips the nurse with the particular skills and knowledge required to care for patients with non-curable and terminal illness and to support the patient's family members. This short course is run as a collaborative venture between HPCA and FPD.

WHO SHOULD ENROL?

All professional and enrolled nurses registered with the SANC who care for patients with life-threatening illness.

ASSESSMENT / CERTIFICATION

Formative and summative assessment methods are used to evaluate learning at both theoretical and practical levels. To qualify for the certificate of completion for this short course, participants should fully attend the workshops, successfully complete the assessment process and complete the clinical work.

COURSE DESIGN

The course consists of 3 parts:

1. Day release learning based on methods suitable for adult learners.
2. Assessment component (examination, communication skills and portfolio).
3. 128 hours clinical work – done in a HPCA approved Hospice.

COURSE STRUCTURE

1. Describe the development of palliative care and its role within the health care system and apply legal, ethical and professional principles in the care of patients and families, with particular reference to death and dying.
2. Describe the management principles of pain and symptom control in advanced illness with particular reference to malignant disease, HIV and AIDS, progressive neurological disorders and end stage organ disease.
3. Be competent in the interpersonal communication skills required to establish rapport and facilitate the grieving process with patients, families and colleagues.
4. Demonstrate the ability to understand the developmental stages as applied to social, cultural and spiritual dimensions in the provision of palliative care based on respect for the uniqueness of the individual.

Starting date:

February - 2012
Day Release: 9 February 2012
Distance Learning: 6 February 2012

REGISTRATION Educational Grant

This course is partially sponsored through an educational grant from HPCA

All interested nurses can apply for this grant from:

LeshokoKomane

Tel: 012 664 8538
Fax to email: 086 513 9814
Email: lesoko@hpca.co.za

COURSE FEE R 6 740

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